Nursing World

NOVEMBER 1958

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By Phyllis S. Howe, B.S., Nutrition Instructor, West Contra Costa Junior College, San Pablo, California. 219 pages, illustrated. $2.75. *New (2nd) Edition!*

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Nursing World

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IN THIS ISSUE

COVER: As Linda Hardie, R.N., takes the pulse of the patient undergoing dialysis, Dr. Alan Mead, a resident on the dialysis team at the Second (Cornell) Medical Division of Bellevue Hospital, and Dr. Norton Spritz, an attending physician at Bellevue, check the artificial kidney to be sure there are no leaks. The process is explained in "Dialysis With the Artificial Kidney" (page 10).

Helen F. Callon

Helen F. Callon, R.N., author of "How the Nurse Can Combat Staphylococcal Infections" (page 8), has led an active nursing life in varied fields. Presently working with the Wisconsin State Board of Health as nursing consultant, Miss Callon was formerly on the operating room staff and head nurse at Bartholomew County Hospital, Columbus, Ind.; delivery room head nurse, New York Hospital; outpatient supervisor and instructor at Chicago Lying-In Hospital. She has also been a public health nurse for the Indiana State Board of Health and chief nurse in the U.S. Army Nurse Corps. She is a graduate of Indiana University.

Glenn D. Lubash

In "Dialysis With the Artificial Kidney" (page 10), Glenn D. Lubash, M.D., chief resident in medicine at the Second (Cornell) Medical Division, Bellevue Hospital, New York City, discusses the increasing use of hemodialysis since the introduction of a disposable coil artificial kidney. Dr. Lubash graduated from the State University of New York College of Medicine in New York City, and has done his postgraduate training as intern and assistant resident at the Cornell Division. He has worked on the dialysis team at The New York Hospital and New York Veterans Administration Hospital, as well as at Bellevue.

Beulah Miller

Beulah E. Miller, R.N., in "The Patient and His Will" (page 14), explains some legal aspects of nursing, so that nurses may be better prepared to meet the total needs of the patient. A graduate of Easton Hospital School of Nursing, Easton, Pa., Miss Miller received a B.S. from the University of Pittsburgh School of Nursing, an M.Litt. from that university's graduate school, and an Ed.D. from the School of Education of New York University. Before joining the faculty at Rutgers, Miss Miller had served in numerous positions, including that of educational director of a three-year hospital school program.

William A. Hunt

In addition to his duties as chairman of the Department of Psychology and professor of psychology and the biological sciences at Northwestern University, William A. Hunt, author of "Education—The Dream and the Reality" (page 26), serves as consultant in clinical psychology to the Surgeon General of the Army and Navy, chairman of the Human Factor Subpanel of the Army Scientific Advisory Panel, and consultant to the Assistant Secretary of Defense. He is also an associate editor of the *Journal of Clinical Psychology*.

Samuel M. Feinberg, M.D., concludes his four-part series on allergy this month with a discussion of "Allergy in Children: Some Special Problems" (page 31). Dr. Feinberg is an honorary member of the French, Scandinavian, Spanish, Argentine, Peruvian, and Cuban Allergy Associations.

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NURSING WORLD

REPORTS

Contest

Austenal, Inc., manufacturers of Vitallium surgical appliances and instruments, will present awards to the 10 operating room supervisors and operating room nurses who offer the best ideas or constructive suggestions on the use, handling, storing, or packaging of Vitallium products in the "Vitallium Viewpoint" contest. The first prize is an all-expense-paid trip to the 1959 Association of Operating Room Nurses Convention in Houston, Texas.

The second prize is a round-trip flight to the convention. The third prize is a cash award of $100, the fourth and fifth prizes are $75 awards. Nurses who win the sixth through tenth places will each receive $50.

All entries should be sent to "Vitallium Viewpoint," Surgical Division, Austenal, Inc., 224 E. 39 St., New York 16, N. Y., postmarked not later than midnight, Nov. 15, 1958. The entries must include the name, home address, phone number, and hospital where the applicant is employed on each page submitted.

Cardiovascular Scholarship

The Nursing Committee of the Nebraska Heart Association is presently studying applications it has received for the association's third $1,200 scholarship for cardiovascular disease nursing.

The scholarship provides one-quarter of study at the University of Minnesota, including living expenses. The recipient of the study grant is expected to be announced shortly.

"Hand in Hand"

"Hand in Hand for Rehabilitation" will be the theme of the 1958 Annual Convention of the National Society for Crippled Children and Adults, the Easter Seal Society, which is to be held in Dallas, Texas, Nov. 16-20.

During the convention, professional workers, parents, volunteers, and friends of crippled children and adults will hear specialists discuss and demonstrate the newest techniques in care and treatment of the handicapped.

The opening institute will be concerned with "The Brain Injured Child." The handicapped child's physical and emotional needs will also be discussed at the convention, and a special cerebral palsy forecast will be featured.

Three Scholarships Awarded

The Boston University School of Nursing recently awarded one-year scholarships to three graduate nurses who will specialize in public health nursing.

Recipients of the scholarships were June E. Harcourt, who has been associated with the Quincy City Hospital; Evelyn E. Birt, a private duty nurse at Malden Hospital; and Barbara M. Clarke, staff nurse at the Massachusetts General Hospital, Phillips House. They will be candidates for B.S. degrees.

The scholarships were awarded under a grant of $11,475 from the United States Public Health Service.

78th Class

Ninety-four students recently registered for the 78th class of the Philadelphia General Hospital School of Nursing. Before starting their regular classes, the students took part in a series of orientation seminars and get-acquainted meetings.

The school, which conducts a three-year educational program, was founded 73 years ago by Alice Fisher, one of Florence Nightingale's students.

Receive Anesthetist Training

Fifteen United States Air Force Nurse Corps officers will undergo nurse anesthetist training during 1959. Chosen for a one-year course at Walter Reed Army Medical Center, Washington, D.C., is Capt. Jacquelyn F. Brodie, Air Transport Squadron, McGuire Air Force Base, N.J. First Lieut. Adele C. Wnuk, USAF Hospital, Langley Air Force Base, Virginia, will train for a year at Fitzsimons Army Hospital.

Those chosen for the eighteen-month training course at the USAF Hospital at Lackland Air Force Base, Texas, are First Lieutenants Rita D. Carson, USAF Hospital, James Connally Air Force Base, Texas; Mary A. Brunner, USAF Hospital, Offutt Air Force Base, Nebraska; Wayne R. Bray, USAF Hospital, Carswell Air Force Base, Texas; and Second Lieut. Philip DiBlasi, USAF Hospital at Lackland.

Undertaking eighteen-month nurse anesthetist training at civilian institutions are First Lieutenants Florence S. Bryant, Robert E. Linn, Josephine M. Palmerino, William C. Herman, Kenneth E. Butler, Gerald W. Kelly, Shirley J. Delany, Elvin G. Robertson, and Second Lieut. David E. Robertson.

Address Change

The Louisiana State Board of Nurse Examiners is now located at 307 Louisiana State Office Building, Civic Center, 325 Loyola Ave., New Orleans 12, La.

New Location

The graduate program of the Department of Nursing Education of St. John's University, Brooklyn, N.Y., will be held at the university's Long Island Division in Hillcrest (Queens), N.Y., beginning this term.

New Fee Policy

The Board of Directors of the National Association for Practical Nurse Education, on the recommendation of the NAPNE's accrediting committee, recently approved a new fee policy for its accreditation and consultation service to schools of practical nursing. The plan calls for charging a flat fee for a survey, regardless of the location of the school requesting the survey. Formerly, there had been additional charges for shared travel and maintenance.

The fee for an application for accreditation is now $25, and a consultation visit is $35 per day, per person, plus travel and maintenance. The annual service fee for one program is $25; for more than one program, it is $50.

The fees for new surveys and resurveys are $200 for a school with one preclinical program in one center, $250 for a school having day and evening programs. For a school with a preclinical program in two or more centers, the fee is $300; if this school has an evening program also, the fee is $350.

Project Directors

Three Army Nurse Corps officers from the Walter Reed Army Institute of Research, Washington, D.C., are to

serve as project directors of disaster nursing programs in three university nursing facilities during the 1958-59 school year.

The research project, financed by the Federal Civil Defense Administration, is designed to prepare a plan for nursing education in national defense by integrating the concepts of disaster nursing into the various nursing programs—in-service, practical nursing, basic diploma, basic college, graduate.

Lieut. Col. Ida G. Price has been assigned to Teachers College, Columbia University; Capt. Drusilla Poole is assigned to the University of Minnesota. Capt. Virginia M. Farrell has been assigned to Massachusetts General Hospital. Grace Davidson, an A.N.C. Reserve officer on the nursing staff of Skidmore College, will be project director at Skidmore.

The National League for Nursing has contracted for, and is sponsoring, the project.

Detection Role

Pointing out that 95 per cent of mentally retarded children are not hospitalized nor placed in institutions, Mrs. Laura Dittman of the United States Department of Health, Education, and Welfare, recently stated that "both visiting nurses and clinical nurses are in a critical position to make early identification of cases of mental retardation." The specialist in child growth made this statement before 100 nurses attending a conference sponsored by the University of Michigan School of Nursing, Extension Service and the Michigan League for Nursing, which was held Sept. 16-17.

Mrs. Dittman told the conference that the nurse "must consider the retarded child simply as one part of a family, all of whose members have rights and needs which should not be compromised even while training the retarded child to his maximum ability."

Dr. Frank Parcells, psychiatrist at Children's Hospital in Detroit, Mich., also spoke during the conference, discussing emotional disturbances seen in preschool children and the effects of physical illness and handicaps.

Assistant Executive Director

Anna M. Ference, president of the Greater New York Association of Industrial Nurses, has been appointed as assistant executive director of the American Association of Industrial Nurses. She was formerly occupational health nurse consultant with the Employers Mutuals Insurance Company of Wausau.

Miss Ference is a graduate of the Lenox Hill Hospital School of Nursing in New York City; she received a B.S. in Nursing Education from Teachers College, Columbia University. At one time, Miss Ference served as director of nursing at Flushing Hospital and School of Nursing, Flushing, N.Y.

Navy Nurse Candidates

Six members of the Navy Nurse Corps Candidate Program, all senior students at Boston College, School of Nursing, recently toured the aircraft carrier USS Antietam. The tour was planned to give the officer candidates a preview of Navy life aboard ship.

The students who visited the ship were Claire L. Haynes, Mary Elizabeth Powell, Nancy J. Hunt, Nancy E. Holmes, Helen A. O'Regan, and Elizabeth M. Grady. Lieut. Commander Natalie Dewar, Nurse Corps, United States Navy, conducted the tour.

Lieut. Commander Natalie Dewar, Nurse Corps, United States Navy, center, took a group of Navy Nurse Corps candidates on a tour of the aircraft carrier USS Antietam (CVS 36). The candidates, from left to right, were Claire L. Haynes, Mary E. Powell, Nancy Jeanne Hunt, Nancy E. Holmes, Helen A. O'Regan, and Elizabeth M. Grady.

The Navy Nurse Corps Candidate Program, established in 1957, is an educational program designed to select as candidates qualified nursing students who are within nine months of receiving their baccalaureate degrees. The applicant must be matriculated as a full-time student in a basic collegiate school of nursing which is fully accredited by the National League for Nursing.

Applicants chosen for the program are enlisted as Hospitalmen (WAVES) in pay grade E-3, which entitles them to $99.37 per month during their final year in nursing school. When the school does not provide tuition, books, incidental fees, or room and board in a dormitory residence, the Navy bears the costs.

Once the nurse graduates with the baccalaureate degree, she is commissioned as an ensign in the Nurse Corps, U.S. Naval Reserve. She is obligated to serve two years of active duty. The period commences on the date she reports to her first permanent duty station following indoctrination.

P.N. Programs Grow

There are now 38 schools with practical nurse programs—with nine more being established—in New York State, according to the Office of the Secretary of the State Board of Examiners of Nurses.

Fourteen of these programs are part of vocational high school programs; nine are adult education; 10 are under hospital auspices; four are within independent auspices; and one program is connected with the State University.

Office Safety

Most accidents that occur in office buildings are the result of disregard of common safety rules, according to Mary Katherine Burke, industrial nurse for Stone & Webster Engineering Corp., Boston, Mass.

Included in these accidents resulting from human error are falling on stairs, slipping on floors, and colliding with

(*continued on page 33*)

New strains of staphylococci — which can survive without a human host — have invaded some hospitals and infected patients and newborn. The author discusses possible reasons for the spread of the infections and methods of prevention.

how the nurse can *combat* STAPHYLOCOCCAL INFECTIONS

by **HELEN CALLON, R.N.**
Consultant in Nursing, Bureau of Maternal and Child Health, State Board of Health, Madison, Wis.

NEWLY recognized strains of staphylococci, characterized by the ability of the staphylococci to colonize in the nose, throat, and skin of apparently healthy individuals and their resistance to the most widely used drugs are now appearing in hospitals throughout the world, causing infections in hospitalized patients and newborns.

The most common strain is phage type 80/81. All agree that this pathogenic phage type of staphylococci is very common in the hospital environment. These cocci can survive apart from the human host.

Hospital practices have changed greatly in the last two decades, and hospitals are now more widely used because (1) people accept hospitalization more readily and are demanding new facilities, (2) more women are working and are unable to care for sick members of the family at home, and (3) prepaid hospital insurance is widely utilized. Furthermore, new diagnostic facilities and surgical procedures are now available in hospitals, and physicians prefer to treat patients there.

The demand for hospitalization is far greater than the availability of facilities and trained personnel. As a result, several practices have developed which may explain the spread of staphylococcal and other infections. One such practice is the overuse of antibiotic drugs and germicidal solutions. Also, the principles of aseptic technique may be less emphasized in hospital procedures and practices than previously. The increased utilization of semiprofessional or nonprofessional personnel, forced upon hospitals by the shortage of trained workers, is another possible cause, and the crowding of hospitals (which promotes the use of short-cuts and makes difficult even ordinary housekeeping procedures) cannot be overlooked.

Another reason for the spread is that more people now survive, due to advancement of medical science; some of these have lowered resistance to infection and may spend long periods of time in hospitals. In addition, more babies who are susceptible to infections are being born in hospitals.

Authorities may differ on the importance they attach to the various ways in which infection may occur in the hospital. Some theories follow:

► Patients may be infected with the hospital strain of staphylococci before admission. No data are available as to the importance of this source, but it appears to play a role only in new outbreaks.

► There may be carriers among personnel, including permanent carriers, who harbor the hospital strain within their bodies for months or even years, while themselves free of clinical symptoms; chronic carriers, who may have repeated skin infections (boils); and temporary carriers, in whom skin or mucous membranes of the nose and throat are colonized with the staphylococcus only for a short time. (This may clear up spontaneously.)

► Equipment, such as ambulance carts, used with infected cases may become contaminated and spread the infection. Staphylococci survive in the environment without a human host, and some investigators emphasize this as a cause for the spread of the disease.

► The newborn nursery is believed by some to be the origin of outbreaks of this infection.

Prevention Procedures

The most effective means of control of infection is to anticipate its occurrence and take measures to prevent full-scale outbreaks. This requires an awareness of potential outbreak. General knowledge of infection should be had by all personnel; they should be aware that localized redness of skin, swelling, pain, or abscess formation may be caused by these cocci. Elevated temperatures and other evidence of systemic complications should be reported to the physician and charted.

Establishing a committee on infections is recommended by many professional groups. Such a group should consist of the hospital administrator or his delegate, the director of laboratories, a representative of the medical staff, the director of the nursing staff or her representative, and the local health officer. The latter may serve as consultant. The chairman of the committee should be interested, have the energy, technical knowledge, and authority to carry out recommendations of the group.

The duties of committee members are varied. They should encourage all hospital personnel and physicians to report any current illnesses suggestive of staphylococcal infection to the hospital health service or nursing office. Elimination of economic penalities (loss of sick leave or pay) for reporting is recommended. Members also establish channels for reporting all hospital infections. To do this requires the teamwork of the medical, nursing, and laboratory staffs. The committee members consider routine cultures of nose, throat, and skin of exposed personnel and patients. The committee should outline and direct details in this practice.

It is up to the committee to establish

The author is grateful to Dr. Josef Preizler for his assistance in the preparation of this article.

a plan through local health authorities for follow-up of cases discharged from the hospital (telephone surveys have been used in some communities) and to review hospital practices and procedures so as to eliminate possible sources of infection and cross-infection.

The Joint Commission on Accreditation of Hospitals emphasized, in August 1958, that clean and aseptic techniques be practiced in all services of the hospital. These techniques may vary from hospital to hospital, as well as from year to year. Most authorities agree that the basic principles have been known for several years, but a new look at good, accepted techniques in the light of the knowledge of today's drugs and individual hospital facilities and personnel may help in controlling this and other infections.

Staphylococcal infection is being studied by many medical and nursing groups. Suggestions of these groups pertaining to specific areas are mentioned below.

Operating Room

The sterile instruments, packs, and solutions should be cultured periodically by bacteriological examination, since mechanical failure, improper packing, timing, drying, and storage may prevent desired asepsis. The cleaning of operating rooms between cases and inspection of air conditioners and ventilating units are important, and these methods should be reviewed. Dust and contaminated cleaning equipment must be considered potential spreaders of infection.

Mechanical equipment that cannot be sterilized must be thoroughly cleaned with an antiseptic and a detergent and stored dry. The patient should have a change of ward linens (gown and blankets) before he enters the operating room.

It is important to establish rules for minimal traffic in and out of the operating room and the number of personnel and visitors admitted. Preventing the spread of infection requires that the best uniform, mask, and cap techniques for all persons entering the operating room be used. The mask should be removed, handled by its strings, and placed in the mask bag after each case; scrub suits and uniforms wet from perspiration or worn while operating on an infected case should be changed immediately after completing the operation. Shoes worn in surgery should not be worn out of the unit (some authorities recommend muslin covers for shoes during the operation).

The techniques of scrubbing and soaking of hands and arms, and donning of sterile gown and gloves should be evaluated, outlined, and posted in the scrub room. These techniques should be accepted and practiced by all members of the team.

Techniques of surgical preparation and draping of patients, handling of sponges, instruments, sutures, and other ways in which the surgical team might inadvertently contaminate the sterile field should be reviewed. A plan should be devised to reserve certain operating rooms for clean cases.

Recovery Room

The equipment used for clean and infected patients should be kept separate, and personnel caring for infected patients should not come in contact with clean patients. In this area it is also necessary to study the dangers of cross-infection in relation to uniforms, washing of hands, litters, and blankets.

Newborn Nursery

Techniques recommended in *Hospital Care of Newborn Infants*, published by the American Academy of Pediatrics, are still valid. In March 1958 the Academy made further recommendations. These recommendations include using rooming-in whenever possible. If infants are kept in a central nursery, use rotating nurseries; admit all newborns to one room, keeping together all infants born within a period of 48 hours. When these infants have been discharged, clean the room and all equipment thoroughly before using the nursery again.

The Academy also recommends that an infant be given a three per cent hexachlorophene bath after birth and every other day, adding that care should be taken not to abrade the skin by rubbing. Individual crib care for each infant and gown techniques should be strictly enforced. The hands and arms of each person entering the nursery should be scrubbed with a detergent containing hexachlorophene. Washing hands, wrists, and arms thoroughly and carefully before and after handling each infant is essential. All infants with suspicious-looking skin lesions should be isolated immediately. Any evidence of infection around the cord should be reported to the physician.

Maternity Unit

In this unit, mothers with suspicious skin lesions and mothers of infected infants should be isolated, and all mothers instructed about good hand-washing practices before and after handling of pads and before handling infants or caring for their own breasts.

Other Units

All patients with suspicious staphylococcal infections should be isolated immediately. Preoperative and postoperative patients should be separated, since patients in the hospital for preoperative clinical evaluations may become infected before surgery. Here, as in other areas, nursing personnel must adhere to good hand-washing techniques between all patients. They should also study techniques in which common equipment, such as dressing carts, perineal lights, sitz bath, etc., are used. Individual dressing trays and adequate disinfection are musts.

All patients, especially those flat of back, elderly, or very ill, should be given meticulous care and all oxygen therapy equipment cleaned, disinfected, and dried.

General Prevention

Strict isolation techniques should be outlined for, and observed by, all hospital personnel. *Guide for Prevention and Control of Infections in Hospitals* is a helpful publication in drawing up these techniques.*

All hospital departments, even the dietary, laundry, housekeeping, and laboratory services, must be concerned with improving the method of preventing infections and their spread. The dietary department should review the handling of dishes from isolated patients, and the laundry reconsider the techniques of handling contaminated linens from patients' rooms, nursery, and operating room. The housekeeping department should pay special attention to the general cleanliness of all areas in the hospital, disposal of environmental waste, dressings, and floor sweepings, and care of patient units—daily and after discharge.

It is up to the laboratory to examine its technique of taking cultures and the practices of personnel while making laboratory tests.

Since patients with this infection may be the focus of infection for the entire family and community, all known patients with the infection should be referred, with the permission of the physician, to the public health nurse for follow-up treatment in the home.

Staphylococcal infections are presenting a challenge to every nurse. Due to her proximity to the patient, as well as her experience in aseptic techniques, she is expected to be a leader in observing and teaching techniques which will minimize the spread of this infection. Since she must teach aseptic techniques to many persons, she may feel the need of counseling and assurance. She therefore should not hesitate to use the fa-

(*continued on page 34*)

*It may be obtained from the Health Education Service, P.O. Box 7283, Albany, N.Y., for 50 cents per copy.

Investigating an open artificial kidney are Dr. Victor Vertes of Mt. Sinai Hospital, Cleveland, left, and Doctors Albert Rubin and Warren Braveman of Bellevue.

With the use of the artificial kidney, dialysis has proved to have therapeutic value in the management of acute and chronic renal disease.

DIALYSIS

With the Artificial Kidney

by GLENN D. LUBASH, M.D.
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The author is indebted to Doris Giles, R.N., and Linda Hardie, R.N., for their many helpful suggestions in the preparation of this manuscript. Thomas P. Almy, M.D., director of the Second (Cornell) Medical Division, also reviewed the manuscript and offered valuable suggestions. Albert L. Rubin, M.D., chief of the dialysis team, graciously allowed me to use material collected in his department.

IN FORMER years, hemodialysis with the artificial kidney was limited to patients in a few hospital research centers. The artificial kidneys then available were homemade affairs, complex in construction, preparation, and operation. Dialysis was a major procedure and, although useful as a research tool, its clinical value was questioned.

With the recent introduction of a commercially available disposable coil artificial kidney,* hemodialysis has become more widely available. It has been firmly established that dialysis will reduce morbidity and mortality in renal failure and poisonings due to a variety of causes. Because of ease of operation, many community, as well as university, hospitals have such a unit or are in the process of creating one.

The artificial kidney can be used for emergencies at all hours of the day or night, and physicians, nurses, and technicians must be available. During dialysis, careful clinical and chemical observations are important. Because of these considerations, a team of individuals interested in this specialized procedure is necessary, and an essential part of the dialysis team is the nurse;

*Manufactured by Travenol Laboratories, Inc., Morton Grove, Ill.

the nursing care of the patient before, during, and after the procedure has assumed considerable importance in the success of the dialysis unit.

Principle of Dialysis

Dialysis is from the Greek, meaning "a separation," i.e., some substances are separated from others by a membrane. In dialysis with the artificial kidney, a semipermeable Cellophane membrane is employed to separate the patient's blood from the dialysis bath. Certain blood constituents, including electrolytes, glucose, urea nitrogen, and body water pass through the membrane freely. Other compounds of larger molecular weight are denied transport. In actual practice, the patient's blood is brought into equilibrium with a dialysis bath of approximately normal plasma electrolyte composition though the semipermeable membrane. Because the patient's blood moves past the membrane continuously, because the membrane surface is large, and because the dialysis bath is of considerabl volume, great exchange of dialyzable substances takes place.

The artificial kidney consists of a large tank with a smaller compartment in the middle. One hundred liters of tap water with added salts and sugar (the concentration of each electrolyte approximates that of normal blood) are used to fill the large tank. The disposable Cellophane coil is placed in the smaller compartment. Dialysis takes place in the coil, which consists of Cellophane tubing wound around a metal support much the way thread is wound around a spool. Each layer, however, is separated from the next by a fiberglass support. The patient's blood enters and leaves the coil through presterilized plastic tubing; a sigmamotor pump is part of the apparatus. A 90 per cent oxygen-10 per cent carbon dioxide gas mixture is bubbled through the dialysis bath to help keep the pH constant.

In order to accomplish dialysis, a source of blood from the patient and a return site must be available. This is achieved by surgical cutdowns, usually performed at the radial artery (source) and the antecubital vein (return). Presterilized large-bore plastic catheters are introduced into these blood vessels and connected to the plastic tubing leading to and from the coil. Occasionally the radial artery is too small to provide an adequate flow of blood. In such patients a catheter is introduced into the inferior vena cava through the external saphenous vein in the groin.

While the cutdowns are being performed, the coil is filled first with saline and then this is replaced with two units of whole blood from the blood bank. The arterial tubing passes through a pump which kneads it and drives the blood through it at rates of 200 to 400 cc. a minute. The patient's blood passes through the tubing into the coil and then back to the patient's vein through a filter which traps air and clots. Heparin is administered to prevent clotting in the coil.

The bath fluid is pumped over the coil continuously, and exchange of electrolytes takes place through the minute pores in the Cellophane membrane. These pores are too small for the passage of bacteria and red cells, but electrolytes pass through freely. As with any semipermeable membrane, osmosis occurs and electrolytes in the two fluids are brought into equilibrium.

The artificial kidney has no direct therapeutic effect on the patient's own kidneys; it merely performs some of their work and removes some of the abnormal metabolites which have accumulated. The time of the procedure may vary, but most commonly there are bath changes every two hours and the entire treatment lasts six hours.

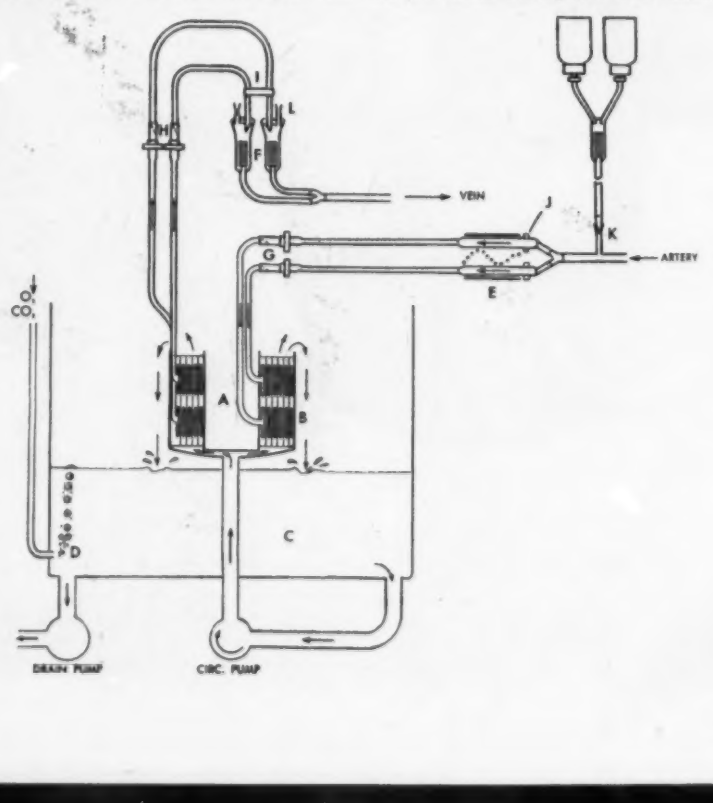
Preparation for Dialysis

The patient is prepared for hemodialysis by shaving the skin at likely sites for the cutdowns; two to five bottles of whole blood are crossmatched against the patient's blood and against each other. If able to eat, the patient may have a light breakfast. The nurse should reassure the patient concerning pain—except for discomfort while the cutdowns are being prepared, dialysis is a painless procedure. Of course, permission for hemodialysis must be obtained from the patient or the family, and the nurse should check to see that this is done. In certain cases, placement on the critical list will be desirable, and the nurse should also check on this. Immediately prior to dialysis, the patient is weighed and the blood pressure, pulse, respiratory rate, and temperature are checked several times to provide a guide for later comparison.

Preparation of the dialysis room is more complex; usually a specially prepared treatment room is used for the procedure. The equipment which the nursing staff must assemble falls into several categories: surgical, glassware, sterile solutions, medications, and miscellaneous.

The surgical equipment for cutdowns includes two cutdown sets, sterile towels, sterile gauze, surgical gloves and masks, several rolls of adhesive tape, rubber tourniquets, and a clean-up tray with 1 per cent or 2 per cent procaine.

A cross section of the artificial kidney, including the coil and tubing, is shown below. Its parts are as follows: (A) dialyzing unit, (B) permanent container for coil, (C) 100-liter tank for dialysis fluid, (D) CO_2-O_2 inlet, (E) blood pump, (F) filter chamber (trap), (G) connection in tubing to coil, (H) connection in tubing to patient, (I) plastic ring around tubing, (J) plastic stop, (K) side arm for transfusion and infusion, and (L) side arm on filter chamber. The arrows indicate the direction of the flow of blood and dialysis fluid throughout the "kidney."



The glasswares needed for the procedure are at least twenty 10-cc. and twenty 20-cc. syringes and numbers 20 and 22 needles. The 10-cc. syringes and number 22 needles are used for medications, the 20-cc. syringes and the number 20 needles for obtaining blood samples.

Sterile solutions should include at least two 1,000-cc. and two 500-cc. bottles of saline, which will be used for filling the coils of the dialysis unit and for rinsing test tubes (clotting times, etc.). Four 1,000-cc. bottles of 10 per cent dextrose in water (or one 1,000-cc. bottle of 40 per cent dextrose in water) are used in the preparation of each dialysis bath. At least 16 bottles should be on hand for four bath changes.

The diluents used in hemodialysis include three 30-cc. ampules of sterile saline and two 30-cc. ampules of sterile water. Cardiotonic drugs (rapid and slow acting) are ouabain, two 0.5-mg. ampules; and digitoxin, six 0.2-mg. ampules.

Other drugs for cardiac emergencies include aminophylline, four 250-mg. ampules; hexamethonium, one 10-cc. bottle (25 mg./cc., which will be diluted to 2.5 mg./cc.); nor-epinephrine (Levophed), two 4-mg. ampules; and Demerol, 50 mg. Anticonvulsants used are Sodium Amytal, two 500-mg. ampules; and Dilantin, one 250-mg. bottle.

Aqueous heparin (six 10-cc. bottles of concentration 10 mg./cc.) is the anticoagulant usually employed. When it is necessary to counteract heparin, protamine sulfate (two 50-mg. ampules) is used.

There should also be available two 100-mg. bottles of hydrocortisone, two 100-mg. bottles of Benadryl, and antibiotics as indicated.

Although wasteful if no emergencies occur, it has proved expedient to have most of the medications drawn up in 10-cc. syringes and labeled with a glass marking pencil as to drug and concentration of drug per cc.

If the patient is comatose or semicomatose, it is advisable to have on hand apparatus for suctioning the patient and administering oxygen. A mouth gag is essential in the event of convulsion. A tray of clamps should be in the dialysis room in case a leak develops in the tubing of the unit. Two filled tanks of 10 per cent CO_2-90 per cent O_2 (for the dialysis bath) must be in the room.

Dialysis

During dialysis, the nurse is responsible for close observation of the patient and for recording these observations. Any sign of respiratory difficulty, cyanosis, twitching, convulsion, or change in pulse should be reported immediately to the physician in charge. Since heparin is administered during dialysis, bleeding may be a complication. The patient should therefore be inspected frequently, particularly at the cutdown sites, for any sign of bleeding. Changes in blood pressure also are common. In the early minutes of dialysis, as fluid is pumped through under pressure, the coil expands and creates an increased area which must be filled with blood. If this occurs at the patient's expense, blood pressure will fall. This can be corrected easily by the rapid addition of whole blood into the coil through a side arm in the tubing. However, frequent blood-pressure determinations are essential to detect a drop; later, blood pressure determinations may be taken every 10 to 15 minutes. In the third hour of dialysis or later, an unexplained rise in blood pressure often occurs and must be treated immediately.

In addition, the nurse should be alert to the possibility of a leak or disconnection in the dialysis tubing. If the nurse fails to notice such a break, the patient may bleed to death in a matter of minutes.

The disposable coil, which is placed in the smaller (middle) compartment of the artificial kidney, consists of Cellophane tubing wound around a metal support like thread on a spool. Each layer, however, is separated from the next by a fiberglass support.

Fortunately, these complications are rare; it is much more usual for the procedure to progress smoothly. During dialysis, the patient may eat a light lunch, read, or even smoke.

After Dialysis

After the catheters are removed from the blood vessels, the patient is weighed and returned to his room, where close observation should be continued. The nurse must still watch carefully for changes in vital signs and for the appearance of cyanosis, respiratory difficulty, and change in the patient's state of consciousness. In certain patients, convulsion precautions—mouth gag, side rails, and restraints—will be necessary. The sites of the cutdowns should be inspected frequently for phlebitis, which occurs in rare instances.

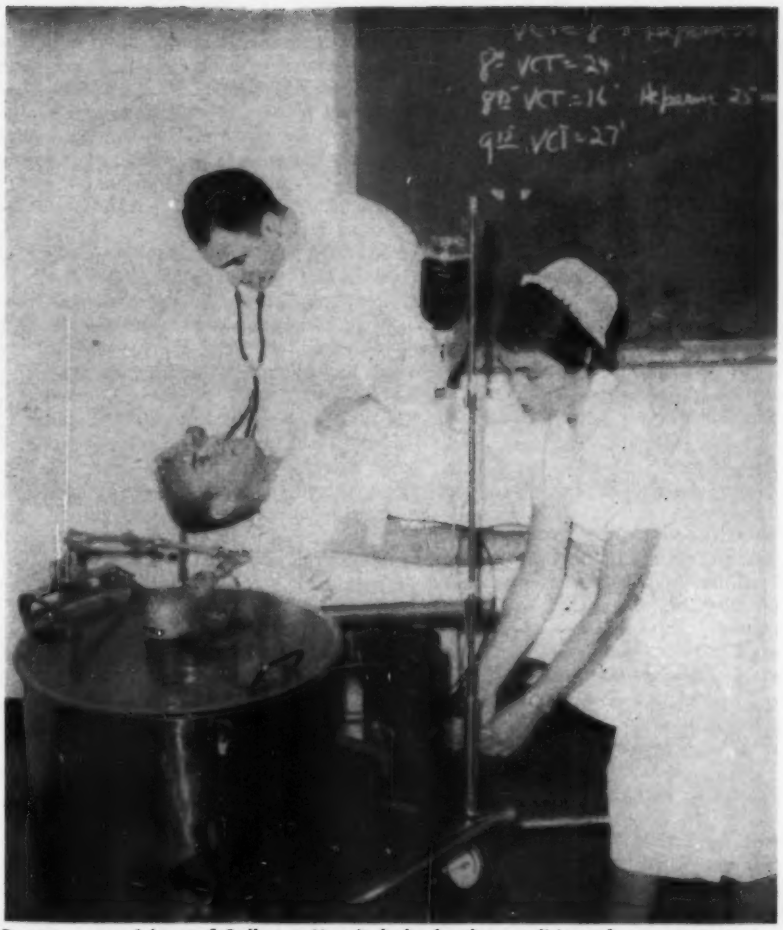
Hypertensive crises occasionally occur within hours of dialysis, and a febrile period may be seen 24 to 48 hours after the procedure. Rarely, dialysis is followed by a temporary period of reduced urinary volume. None of these complications should be taken for granted. All should be reported to the physician for further investigation.

Intramuscular injections are contraindicated for at least 12 hours after dialysis. The patient will have received the anticoagulant heparin, and oozing may occur at injection sites. Antibiotics, if indicated, should be administered per os or intravenously.

The careful measurement of intake and output in the postdialysis period cannot be stressed too much. All vomitus, aspiration material, perspiration, and fecal and urinary losses should be measured or, if this is not possible, estimated.

Discussion

Dialysis with the artificial kidney has proved to have therapeutic value in the management of acute and chronic renal disease, and patients with temporary urinary suppression may be tided over a period of uremia. In addition, many patients with various forms of chronic renal disease and uremia have been helped symptomatically. Repeated dialysis in these individuals has lengthened their productive life and reduced morbidity. While some patients improve dramatically during dialysis, clinical change may not be apparent in others for 24 to 48 hours. Occasionally, there is no improvement. The limiting factor in the treatment of uremia is the functional capacity of the patient's own kidneys. The artificial kidney will not alter this, but has proved useful only in helping patients over periods of decreased function. While the selection of patients for dialysis must be individualized, it is obvious that those patients with potentially reversible kidney disease are the best candidates.



Dr. Lawrence Scherr of Bellevue Hospital checks the condition of a patient undergoing dialysis while Linda Hardie, R.N., adjusts the rate of flow of transfusion.

Various poisons will cross the dialysis membrane. The artificial kidney will lower blood levels resulting from toxic doses of salicylic acid (aspirin), bromides, thiocyanates, and certain barbiturates, and has proved useful in the treatment of intoxication with these agents.

In addition to its clinical application, the use of the artificial kidney has contributed to our knowledge of the uremic state. This method of treatment rapidly changes blood constituents and affords an unusual opportunity to study the effects of these alterations. Further research may shed light on some of the basic biochemical abnormalities in uremia.

During hemodialysis, meticulous attention to detail is important. Every dialysis team will make certain modifications in the items mentioned above, but the general principles of management and nursing care are standard. Because no one person can be responsible for all phases of hemodialysis, the team—each with his own responsibilities—has become an important concept. The nurse is an essential member of this team.

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What should the nurse know about the legality of wills? Should she be a witness? These are some of the important questions answered here.

the Patient and His WILL

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"I DON'T care what anyone says, it's about time nurses were really concerned about what the patient wants, needs, and expects," a nurse declared.

"But if it is legally invalid, you would not be doing the patient a service," another nurse retorted.

"But the man was a lawyer," the first nurse added.

"But you are not 21, so your signature isn't—"

"I will be very soon, and as a nurse—"

And so a discussion concerning the role of the nurse and the will of the patient continues, sparked by a request from a lawyer for a nurse to witness the execution of a patient's will.

As professional nurses are we not concerned about what the patient wants, needs, and expects—what a patient wills? Are we satisfied to accept that wills are the business of lawyers and dismiss it as such?

Granted, the drawing up of wills with the complex law it involves is the prerogative of the legal profession. But this neither justifies ignorance of others concerning the subject, nor implies avoidance or refusal by the nurse when confronted with a question or request regarding the will of a patient. A properly executed will is a person's (in this case, the patient's) means of declaring his intentions of what he desires to be done—most commonly the disposition of his property—after death. The laws and legal techniques governing wills have developed over many years and lawyers act within this framework to fulfill and protect a person's desires after he dies.

It is not unusual that a person who is in need of nursing care becomes concerned about things involved with death. Because of this, a nurse needs to have certain knowledge about wills and an understanding of his function in helping the patient to exercise this right. Selected information about wills, and the role of the nurse and suggested responses regarding wills are the major topics to be considered here, while the purpose of this article is to focus attention on a frequently unrecognized aspect of the concept of complete nursing care.

Selected Information About Wills

Some type of law regarding the disposition of man's property after his death has existed ever since man has had the right to possess property. However, the opportunity for each person to declare his personal desires in this matter is relatively recent. Even today there are many who do not exercise this right and are said to die intestate; their property is distributed to heirs under the law of intestacy. These laws regarding wills and intestacy are complex and vary within each state. The following information about wills consists of general information, since specific application requires legal advisement.

Who Can Make a Will?

Although there are legal techniques used by lawyers in drawing up wills, the will is actually made by the person declaring the disposition of his property after death. When the person is a man, he is known as a testator; a woman is a testatrix. There are statutes in all jurisdictions of the United States regulating who may make a will, and the capacity to make a will must exist at the time a will is made; it is not necessarily the capacity that exists at the time of death.

While each state has a minimum age requirement for the execution of a will, there is no maximum age regulation.[1] In a few jurisdictions, however, the age requirement differs for men and women, for disposition of real and personal property, marital status, and a few other specific considerations. In over half the states, the required minimum age is 21, and several of these states make no exception to this. Nevertheless, there are a considerable number of states with a minimum age of 18, and in a few the minimum age is less.

Sex no longer influences the right to make a will, nor does marriage change this right, although marriage after executing a will does in most states revoke the will in order to permit the surviving spouse to receive his or her legal inheritance. Citizenship is not a requirement, and in most instances a criminal may make a will.

To make a valid will, a person is required to have testamentary capacity. Whereas soundness of the physical being is not a requirement for testamentary capacity, soundness of the mind is. Both of these have been questioned and numerous judicial decisions handed down regarding them. Persons found competent to make a valid will have had such conditions as blindness,[2] deafness,[3] and general debilitation.[4] Not only persons with severe pain,[5] but also those near death[6] have made valid wills. Neither brain tumor[7] nor epilepsy[8] necessarily makes incompetency. Illiteracy,[9] below-average intelligence,[10] immoral behavior,[11] alcoholism,[12] addiction to drugs,[13] or insanity[14] have not deprived a person his testamentary capacity. A person is said to have testamentary capacity if (1) he knows what he is doing and is able to understand that he is executing his will, (2) he knows the property that he possesses and has ownership right of that which he declares for disposition, (3) he knows the existence of those to whom his property would naturally be distributed, and (4) he is capable of forming a rational testamentary plan. Even with knowledge of the above, according to Atkinson, "What constitutes sound mind is almost everywhere a matter for the courts to determine."[15]

When Can a Will Be Made?

A will can be made at any time after a person reaches the required age, has testamentary capacity, and has the required number of witnesses present. It is further required that the will be executed at a time when the testator is free from undue influence and/or fraud. It is also advisable that he have sufficient legal counsel to insure the validity of the will. All persons involved in the execution of the will must be present and witness the affixation of all signatures and the date to the document. Needless to add, forgery invalidates a will.

Where Can a Will Be Made?

A will can be made in any place free from undue influence where the testator can assemble (or can have assembled) those persons required by law for executing a will. It is essential that the geographic location be properly stated on the document because the validity of the will is generally dependent upon the laws of the jurisdiction in which the will is executed.

What Can Be Disposed of by a Will?

Not all property owned by a person can be disposed of by a will. Papers, such as United States Savings Bonds and insurance policies, which name a beneficiary are not subject to the declaration of the will unless said beneficiary is listed as payable to the person's estate. Joint ownership property has special laws regulating its disposition. With few exceptions all other property can be disposed of by a will. At one time real property was disposed of by a will and personal property by a testament, therefore the reference to the instrument as the "last will and testament." Since real and personal property are usually subject to different regulations, they are frequently referred to separately. Real property—real estate or land with its buildings and immovables, such as fences and growing trees—is given and devised, while personal property is given and bequeathed. Personal property may be further classified as movables or corporeal, such as animals and jewels, and incorporeal, such as copyrights and patents.

Although disposition of property is considered the usual purpose of a will, other declarations of what the testator desires done after his death can also be included. An example is funeral specifications.

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[1]Gambill's Adm'r v. Gambill, 236 Ky. 491, 33 S.W. 2d 325 (1930); Collins v. Townley 21 N.J. Eq. 353 (1871); Wilson v. Mitchell 101 Pa. 495 (1882); ages of testators: 80, 90, and 100 years, respectively, did not invalidate the will.

[2]Collis v. Walker, 272 Mass. 46, 172 N.E. 228 (1930).

[3]Potts v. House, 6 Ga. 324, 50 Am.Dec. 328 (1849).

[4]In re Brown's Estate, 55 S.D. 53, 224 N.W. 942 (1929).

[5]Stevens v. Leonard, 154 Ind. 67, 56 N.E. 27 (1900).

[6]In re Vesper's Estate, 4 N.J.Misc. 791, 134 A. 651 (1926).

[7]In re Fricke, 64 Hun 639, 19 N.Y.Supp. 315 (1892).

[8]In re Derusseau's Will, 175 Wis. 140, 184 N.W. 705 (1921).

[9]In re Carter's Will, 60 N.J.Eq. 338, 51 A. 65 (1900).

[10]In re Whitworth's Estate, 110 Cal.App. 526, 294 P. 84 (1931).

[11]Leach v. Alger, 302 Ky. 149, 194 S.W.2d 164 (1946).

[12]In re Donnelly's Estate, 148 Misc. 5, 266 N.Y.Supp. 506 (1933).

[13]In re Anderson's Estate, 142 Okl. 197, 286 P. 17 (1930).

[14]Insane with guardian appointed for property by court may make will; Nichols v. Wentz, 78 Conn. 429, 62 A. 610 (1905); Reeves v. Hunter, 185 Iowa 958, 171 N.W. 567 (1919); insane with delusion not affecting will; In re Greene's Estate, 40 Ariz. 274, 11 P.2d 947 (1932).

[15]Atkinson, *Handbook of the Laws of Wills*, second edition, 1953, p. 236.

How Can a Will Be Made?

There are jurisdictions where a holographic will—one written entirely by the hand of the testator without witness—if completed with date and signature, is valid and must be recognized. However, it may present a considerable burden to all concerned when it is admitted to probate. Lawyers caution against making holographic wills, but if a paper that may possibly be a handwritten will is found, it should be taken to a lawyer for proper appraisal and follow-through.

Then, too, there is the nuncupative will or oral will. The oral will is valid only within certain legal limitations, and then not in all jurisdictions. Some of the limitations are that the person be in immediate danger of death and actually die from that cause within a specified period following the time the will is made, and depending upon the jurisdictions, as many as three witnesses who are not beneficiaries must be present. When possible a word-by-word written record should be made of the oral will. Of course, the person making the will must have testamentary capacity. The legal action which follows a nuncupative will admitted to probate may be rather expensive in terms of time and money. Lawyers therefore advise that the oral will be used only under extreme circumstances and revoked as soon as possible by a duly executed written will.

By far the will that best carries out its purpose is the one made at a time when the testator can give profound thought and detailed consideration to all items, and when he can consult with his attorney, since there are many technicalities to be considered in the preparation. The form, terminology, phrases, and clauses used are important for legal interpretation and follow-through in carrying out the will of the testator. The knowledge and the skill of a lawyer and the declared intention of the testator are both necessary to draw up the will. After the instrument is in final form, the testator needs two or three witnesses (depending upon the jurisdiction) while executing the will. Having more witnesses than required does not, however, invalidate the will. In selecting witnesses the testator is advised not to ask a beneficiary because upon serving as a witness, he may forfeit all except his legally established inheritance. The witnesses should be persons that have reached the legal age, know the testator, and will probably be available if needed when the will is admitted to probate. The lawyer may also offer advice about the selection of witnesses.

It is the responsibility of the witnesses to know that the testator has testamentary capacity and is free from undue influence and/or fraud. The witnesses do not read the will, yet, they as well as the lawyer and testator, are present during the entire ritual of execution. This ritual is somewhat influenced by the personal variations of the lawyer and the circumstances, but the pattern of procedure is generally the same. The testator declares and accepts the document as his last will and testament, affixing his initials to each page but the last. There he writes his signature. The will is then passed to each witness, who, in turn, reads the testimonium and attestation clauses. These clauses have no required form, but include the date and, preferably, the number of pages which should be counted by the witness. Any unusual circumstance, such as a blind or deaf testator, is also stated in the clauses. The witness then signs his name and address to the will. After the testator and all the witnesses have signed the will and the necessary affidavits, the witnesses may leave. It should be remembered that erasures and corrections invalidate a will.

Under no circumstance is a will signed in duplicate copies, for this would mean that all copies would have to be admitted to probate. It would also be necessary to have any changes desired in the future to be made on each copy. A will can be revoked or a codicil (a qualification of, or an addition to, a will) made by the testator any time he pleases during his lifetime. The executed will is kept by the testator.

For those nurses who are not familiar with the complexity of the law regarding wills and those who have a desire for additional information about wills, there is a textbook, *Handbook of the Law of Wills* (second edition, 1953), written by Atkinson, that is usually available in law libraries. There is also the book *How To Make a Will* by Parnell Callahan, a member of the New York Bar. This book is written in nontechnical language to introduce people to their legal rights and responsibilities, but is not designed to take the place of an attorney when making a will.

Why Make a Will?

Perhaps the most important reason for making a will is that it is each person's responsibility to make plans for the disposition of his property. Not only does a will provide a legally protected means of having intentions carried out after death, but also it makes the distribution and settlement of the estate less difficult and more rapid. The time element is a significant factor because frequently the beneficiaries are those who have been dependents of the dead person. The "why" of making a will is as personal as his desires, and depends upon the individual, his interests, his property, and his survivors. This needs no further development—it is sufficient that society by its laws has given the right to make a will to each man.

The Nurse and Suggested Responses

Under ideal circumstances, a person would have made a will before becoming a patient or at a time when nursing care was not extensive. When this is not possible, the wishes of the patient and the role of the nurse must be realized. As may be expected, the keystone suggestion and prerequisite to any response by the nurse is—be prepared. It is necessary that the nurse have the same information about wills as any well-informed, responsible person.

It is only because of the previously mentioned circumstance where patients possibly become more aware of the necessity for making a will that nurses need to give special attention to the subject of wills.

This is not limited to the nurse caring for the hospitalized patient, for a situation involving a nurse-patient relationship and a will can and has occurred in the home. It was a private duty nurse caring for a patient in the home of a son-in-law that was an important figure in the case *Matter of Stegman*.[16] The question before the court was whether the instrument under consideration was a last will and testament. The will in question was prepared and witnessed by a nurse who attended the decedent in the home where he lived.

It was decided that the instrument was not the last will and testament of the decedent, and that he had not executed it. The probate was denied and decreed accordingly. With regard to the testimony of the nurse that she had drawn several wills, Surrogate Evans stated, "This practice for a nurse is unwise and such excursions into the field of law should be discouraged. The relation between the patient and nurse is highly confidential. Under such condition the opportunity for fraud and undue influence is too great for safety. The old adage that 'a shoemaker should stick to his last' still has its application. The drafting of wills had better be left to the legal profession."

If a nurse has an understanding of the basic factors about wills, there should be little difficulty in recognizing the responsibility to the patient and the limitations of the nurse with regard to this matter.

[16] 133 Misc. 745, 234 N.Y. Supp. 239 (Surr. Ct.), *aff'd*, 227 App. Div. 647, 235 N.Y. Supp. 890 (4th Dep't., 1929).

The role of the nurse in securing legal aid for a patient can be compared with that of securing any other professional aid. When asked directly by a patient to get his attorney, the nurse should make every effort to contact him. When asked, a nurse does not refer a patient to a specific dentist, physician or surgeon, or a family to a specific funeral director; neither does a nurse refer the patient to a specific lawyer. The nurse may refer the patient to a list of lawyers; usually the most available listing is that in the classified phone directory.

A nurse does not, without sufficient reason, suggest that a patient consider talking with a rabbi, priest, or minister. And she should not suggest legal aid without sufficient reason. If a patient during a conversation laments that he has no will, the nurse can continue with the conversation, agreeing with the advisability of having a will and commenting on the importance of legal assistance for preparing one. The urgency of the patient's wishes undoubtedly will be tempered by his condition. So will the follow-through by the nurse.

If it is obvious that the patient is making a holographic will, the nurse can tactfully caution the patient of the burden "do it yourself" wills may cause and thereby suggest the value of consulting an attorney. Usually the fee for the attorney is considerably less than the expense of establishing the holographic will as the last will and testament. However, the patient retains the right to make a holographic will. The nurse's responses here are not notably different from those made by the nurse in numerous other situations.

If the nurse is present when the patient's attorney unexpectedly arrives, all that is suggested is that he be given the courtesy extended to any person giving professional service to the patient. Inquire as to whether the patient is expecting the attorney and whether he has previously met the patient. Check the desires and status of the patient and continue accordingly. Assuming that the attorney's visit concerns the patient's will, the nurse arranges that they be given as much privacy as possible.

Hopefully, if plans are being made for executing the will during the time the nurse is responsible for the patient, the attorney will notify the nurse. However, due to past experience with some nurses who may not have been cooperative, or due to his own lack of understanding, the attorney may not realize any value in this. Therefore, when it is obvious that the visit concerns the patient's will, the nurse can take the initiative for making plans. The patient and lawyer should select and notify the necessary witnesses; a time convenient to all involved can be scheduled, adequate facilities obtained, and optimum privacy arranged. The planned ritual of executing a will should receive the same considerate attention as the planned ritual of circumcising the infant boy of Jewish parentage.

The same careful preparation should be observed in hospitals where such arrangements might be made by other than a nurse. It is, however, the role of the nurse to collaborate with others who are planning for the execution of the will so that the wishes of the patient will be fulfilled with as little difficulty as possible.

The nurse records in the nurses' notes of the patient's chart the visits made by the attorney, the circumstances and patient's condition that existed at the time the will was executed, and any other pertinent observations. As in all charting, accuracy, succinctness, and legibility are important.

It is true that real-life situations ordinarily do not seem to fit the prefabricated hypothetical situations; all situations are influenced by many variables. The agency or hospital policies, the patient, the presence or absence of a lawyer and the individual nurse—all must be considered. It is conceivable that the patient most desirous of making a will could be one in immediate need of a will, in fact, a nuncupative will may be the only possible will for this patient. This right should not be denied him. In such a case, the declaration of the patient should be written verbatim, repeated to the patient, dated, and signed by the patient. A description of the circumstances under which the oral will was made, the signatures and addresses of the required number of witnesses must be added, and the document, itself, should be placed on the patient's chart. However, every effort should be made to revoke it as soon as feasible with a duly executed written will. The witnesses of a nuncupative will can expect to be notified to appear in court for testimony if it is admitted to probate. Even in emergencies the oral will should be considered by the nurse only as the will of last resort, and then not as final resort.

The selection of witnesses for some patients wanting to make a will may be simple, but for others it may prove difficult. It usually depends upon the availability of the required number of persons. If the patient is in the area of his home or work, it may be rather easy for him to arrange for witnesses; on the other hand, if he has traveled to a distant city for treatment or has been the victim of an accident or a similar emergency, he may know nobody to select. It must also be remembered that those who are most available, such as husband, wife, sons, and daughters, are also most frequently beneficiaries and therefore may not be witnesses. The attorney may decide that the nurse is the best qualified person available to be a witness.

If the nurse decides that it is necessary and possible to be a witness, then all the responsibilities of the witness must be accepted. The nurse, as a witness, must (1) be present during the entire ritual of execution of the will, (2) observe the patient for testamentary capacity and freedom from undue influence and fraud, (3) listen to the testator (the patient) acknowledge the document to be his last will and testament, (4) watch the testator sign the document, (5) read the testimonium and attestation clauses, making certain there are no erasures, corrections, or spaces left blank before the space for the witnesses' signatures, (6) know the proper place on which the signature is to appear, (7) sign carefully, using a legal signature and address, and (8) watch that the other witnesses who have been present for the entire ritual sign their names to the document.

If the nurse has acted in accord with his knowledge and best judgment of what is legally right, along with the direction of the attorney, there should be no fear of future actions. If the nurse believes that all factors are not properly considered, it is a legal obligation as well as a responsibility to the patient to refuse to be a witness. Again, the nurse records in the nurses' notes of the patient's chart pertinent factors concerning the execution of the will. It is expected that the number of patients wanting to make a last will and testament will be relatively small; however, cognizance of the law is essential if the nurse is to give complete nursing care. The nurse who is unwilling to be concerned with the will of a patient may be preventing that patient from accepting his responsibility, and denying him the patient's right.

By the way, do you have a will?

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INTERVIEW with Dr. Mildred L. Montag, R.N., Director Co-operative Research Project of Columbia University

IS ASSOCIATE DEGREE PROGRAM SUCCESSFUL?

Dr. Montag reveals to Associate Editor Julie E. Miale some results of the pilot project of two-year nursing education courses in community and junior colleges.

Q. Dr. Montag, in 1950 experimentation with a two-year junior and community college program in nursing began under your direction. Since then, this new educational idea in the preparation of nurses has stirred nursing education from coast to coast. How did this program start? What brought it about?

A. Probably the most important factor was the acute nursing shortage and the need to prepare more persons capable of performing the functions commonly associated with the registered nurse—those functions of the general duty or staff nurse.

Then, too, there was a need for something more comprehensive than merely increasing the number of nurses to keep pace with the increasing population. The whole problem of nursing education needed to be studied from the point of view of meeting the individual patient's needs, the nurse's needs, and the hospital's needs, as well as the needs of the doctor and community.

Q. Where did this new concept of nursing education originate? Did someone have a hunch? Did you? Did nurses, themselves, set the wheels in motion toward the junior college program, or did the impetus come from outside?

A. Nurses, themselves, seeking ways to improve the quality and quantity of nurses, began thinking about changes in the educational programs. Of course, ideas do not come from groups. Someone gets an idea, then others become interested and eventually it gains enough support to cause a plan to be developed. This is essentially what happened in the associate degree program.

Q. What steps were taken to get this program started?

A. Almost 10 years ago, representatives of the National League of Nursing Education approached the American Association of Junior Colleges to determine if there might be some mutual interest in studying the nursing shortage problem and to attempt to define the responsibilities the junior community colleges might assume for providing educational programs for the preparation of nurses. Some years later, a joint committee was established. A co-ordinated program of research, sponsored by the Division of Nursing Education of Teachers College, Columbia University, known as the Co-operative Research Project in Junior and Community Colleges really started these programs.

Q. As director of this project, you have witnessed the transformation of a novel concept in the preparation of nurses into a national movement. Some 20 articles, 5 books, and 30 studies have been inspired by this new educational idea. Nursing groups all over the nation have devoted entire meetings to consideration of this new type of nursing education, and in at least one state, legislation had to be amended to enable further experimentation along these lines. This is exciting, and many people will want to know when the final report of this committee will be published and what your feelings are generally.

A. I must say it has been an exciting and rewarding experience. The many people who participated in this project are just as enthusiastic as I am. The national committee, college administrators, college faculties, hospital administrators, state boards of nursing, the nursing profession, and many others are hopeful that this study will stimulate some soul-searching of educational policies wherever nurses are taught and that all programs will engage in a continuous evaluation and re-evaluation of curriculum, the techniques and methods of teaching, and graduates.

The full report of this study will soon be published by McGraw-Hill Publishing Company, Inc. The title of the report is *Community College Education for Nursing*.

Q. Dr. Montag, what are the general characteristics of the two-year associate degree program in nursing?

A. Briefly, it is a two-year junior community college program with a nursing major. The nursing program is under the administrative and financial control of the college. The college plans the entire educational program, using such community resources as hospitals, visiting nurse associations, health departments, nursery schools, and any other community agencies that can contribute to the educational experiences of the students.

The curriculum, of true collegiate quality, provides for the acquisition of knowledge, skills, and attitudes which assure competency for employment as a newly registered nurse.

Q. This project came to a close on July 1, 1957. What happens to these programs now that the study is over?

A. They are going on and are growing. Not one of the schools in the project contemplates closing. In fact, none of them saw this program as a temporary measure. Since the colleges and students alike report satisfaction, I am confident these programs will be continued and will continue to improve.

Q. You believe the purpose of the project has been accomplished?

A. Yes, I do. Our purpose was to develop and test a

How did the idea of a two-year nursing education course originate?

What are the general characteristics of this program?

Will the two-year programs continue now that the project is over?

Now an assistant professor of nursing education at Teachers College, Dr. Montag has written many articles and books on nursing.

new type of program for the preparation of young women and men for those functions commonly associated with the registered nurse. This, I think, has been achieved. One of our basic assumptions was that education for nursing belongs in an educational institution, in the organized educational framework of the country, as does all other educational preparation. One of our aims was to determine whether or not a college could take a program of nursing and integrate it into its present operation. This, I believe, we have proved. It does appear to be possible for a college to undertake this kind of nursing program.

Q. How many colleges participated, and how were the colleges chosen for this project?

A. Over 60 colleges requested participation. We reduced that number to around 25 through questionnaires. Then we further reduced the number to eight by individual conferences and visits to the colleges. Specific criteria were established by which we judged those applying. We purposely selected colleges all over the country, large and small ones, co-educational, as well as a women's college, and those with public, as well as private, support.

Q. Can you say how many additional colleges have started programs in nursing since this project began?

A. I believe about 40 more have been established since 1950, and others are eager to start.

Q. Suppose the two-year community college program in nursing catches on and spreads. How many such programs do you think would be needed to fill the nation's need for nurses?

A. That is hard to say now. Certainly not all the nurses needed would be prepared in community colleges. Senior colleges and universities should also be considered in determining the number of schools. It seems to me that considerably fewer schools than we have now would be needed. Many of the present schools are far too small to operate effectively and economically.

Q. There are in the neighborhood of 700 junior colleges in the United States. Is it possible that these colleges will jump into nursing education without adequate planning and preparation, with resultant injurious effects on nursing education generally?

A. I suppose it is possible. Actually, development of these programs should come only after careful planning, and those not ready should be held back. On the whole, the movement of nursing education into the total structure of education should be encouraged.

Q. Have you found that the placing of nursing programs in an educational environment holds more appeal to young women than does the program in a hospital, where they are required to "live in"?

A. Yes, I have, very definitely. An indication of this appeal was evidenced by over a thousand inquiries received following an article in a popular magazine which described the two-year college program for nurses. I think it is appealing to students because they lead a regular college life. They dress as other students do; they participate in many cultural and social activities on campus. They enjoy the freedom and the responsibility of living together, of maintaining apartments and managing finances. All this is a far cry from most hospital schools, where nurses live only with other nurses and often have to observe archaic rules.

Q. What are the basic characteristics of the curriculum?

A. About one-third of the curriculum is in general education. We would classify as general education the biological, physical, and natural sciences, the social sciences, communication skills, and the humanities. For the general education portion, the students take the regularly constituted courses of the college.

Two-thirds of the curriculum consists of nursing courses. These nursing courses are quite different from those in traditional nursing programs. In the first place, there are fewer nursing courses. There is a broader grouping of subject matter. Then, the courses are arranged so that the student progresses from the normal to the abnormal, from the simple to the complex. The hospital or other health agency is used as a laboratory, with the instructor selecting those learning experiences the students need.

The nursing courses are arranged in both years, with somewhat more time spent in nursing in the second year and more in general education in the first year. While the student spends fewer actual hours in nursing practice, those she does spend are planned to be effective learning experiences.

Q. Can the graduate of the two-year program in nursing fit her knowledge and skills into a baccalaureate degree program in nursing? Should she desire to continue her formal education in nursing?

A. Really, the junior college program should be regarded as complete in itself. Its primary purpose is to prepare a bedside nurse, not to provide an introduction to baccalaureate preparation in nursing. Ideally, students who

wish to secure a B.S. degree would enter a baccalaureate program at the outset. However, a junior college graduate would certainly have less trouble in establishing advanced standing than would the three-year diploma nurse, because she has bona fide negotiable college credit.

Q. Has this two-year program been generally accepted?

A. I think the rapid growth of these programs is evidence there is increasing acceptance. The effect of what we've done on hospital schools of nursing programs is further evidence of acceptance. So the effect, I'd say, has been felt in two ways: in the increase in the number of junior college programs, and in the changes in the curricula of existing schools.

Q. Since a program is judged largely on what its graduates are doing, can you tell what the performance of the graduates of the two-year program has been?

A. Our evidence supports the belief that these graduates measure up as competent bedside nurses. From the standpoint of the licensing examinations, the results indicate these graduates are at just about the same mean as graduates of the fully accredited diploma programs.

As far as employment in actual situations, they are being rated as high or higher than the graduates of other nursing programs, and quite consistently higher than the three-year hospital school graduate in the areas of interpersonal relations, interest in patients, and ability to meet needs.

Q. Then, in your opinion, these students are better prepared to do bedside nursing than the diploma school student after graduation?

A. Yes, I think they are, because their concentration of time and effort has been entirely on patient care—bedside care. They have not had to be concerned with the management of the ward or floor. It makes them conscious of the patient's needs.

Of course, the performance of any beginning nurse is largely dependent upon the orientation period in her new position. This applies to any new nurse in any hospital. The practice of providing orientation programs for new employees is standard in industries and offices. It should be so in hospitals too.

One administrator put it this way: "Although at the beginning of her employment the junior college graduate is not as oriented to the hospital as is the hospital school graduate, given a little time she develops a remarkable 'technique in nursing!' She is an eager learner and adapts to situations with ease. She has a remarkable 'You' attitude and is vitally interested in people and especially in patients. She sees each patient as an individual with individual problems. This is true, of course, of graduates of other programs, as well. The graduates of the junior college programs, however, seem to have a 'You' attitude in specially large doses . . ."

Q. Some of these graduates accept positions as head nurses. Are they qualified for supervisory positions?

A. The community college graduate is a bedside nurse; a staff position is the only one for which she is qualified. One of the problems is that the graduates of these programs are being pushed into positions for which they are not prepared, as are probably lots of other graduates. No, these graduates are not prepared to be head nurses, so evaluation of those who have accepted positions as head nurses is no measure of the program itself.

Q. Approximately 85 per cent of all nursing schools are still controlled by hospitals. Only 6 per cent are under college or university control. Another 3 per cent are organized under religious orders, junior colleges, etc. Do you feel that this situation will be reversed?

A. I both think so and hope so. The speed with which this program has developed indicates this.

Q. Would you care to predict how soon?

A. Sooner than we think, if we don't prevent its happening.

Q. A criticism, expressed by a director of nursing, implied that the junior college graduate's preparation was obtained exclusively in the classroom, and that she never could be as expert a nurse as those who spend a large amount of time with patients. Such an attitude is unworthy of mention, perhaps, but would you clarify the point again?

A. The junior college program does not prepare students for nursing exclusively in the classroom. Hospitals and other health facilities in the community are used extensively. The ideals of nursing, along with the sciences, the communications, and nursing skills and arts, are all included in developing these programs. I think that any educator in the country will agree that educational programs do not prepare experts; they prepare individuals to become experts.

I believe that our project will show that the graduates of the junior college programs have the ability to become expert bedside nurses.

Q. Let's move to one or two questions about the present situation in nursing, Dr. Montag. There are so many different kinds of nursing education at the present time—practical schools within and outside the hospitals, diploma schools in hospitals, associate degree programs in junior colleges, four-year college courses, five-year college courses, combinations of these, and graduate courses leading to the master's and doctorate degrees. Isn't this a very confusing picture? Doesn't such multiplicity affect morale and sound nursing service, as well as recruitment?

A. Yes, I believe it does. Many people believe, and I agree, substantially, that eventually there will be only two nursing programs, the two-year associate degree program and the four-year baccalaureate program. And, of course, higher education for administrative, supervisory, and educational positions.

Q. Would you care to state when you think this adjustment might take place?

A. It is hard to predict. But I think it can be done, and in not too many years.

Q. Since that will take some time, do nurses dare to accept passively some of the conditions now forced upon them by overloaded hospitals and the use of thousands of untrained, inadequately supervised helpers in the nursing care of the patients?

A. I think nurses have a distinct responsibility in this area. I believe the problem of use, or misuse, of nursing personnel is greater than the shortage. It is easy in difficult times to use a scapegoat, and I think "shortage of nurses" is being so used. If we really used effectively the nurses we have, and if nurses did *nursing*, our problems would be less severe.

Q. Is the two-year program, as it is set up now, going to be part of the answer?

A. I think it has great potential for helping solve the problem. But these graduates of the community college nursing programs must be allowed to nurse.

Q. Let me ask you just one final question. What do you think of the present nursing situation? What is our greatest and most pressing problem?

A. Education of nurses, both preservice and in-service. Unless we improve both how we prepare nurses for practice and how we help them improve their practice after graduation, we cannot solve our problems. We need to teach nurses to nurse, to help them to achieve satisfaction in nursing, to advance the profession by the improvement of practice. In short, nurses should be prepared to nurse and then to do nursing.

Advances and Trends in

DRUG THERAPY

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The Management of Essential Hypertension

This final article in a series of three concerned with the medical dilemma of essential hypertension will be devoted specifically to a discussion of current concepts and controversies involved in the management of essential hypertension. In previous articles the genesis of the disease and the clinical courses of both benign and malignant hypertension were investigated.

Since the etiology and pathogenesis of essential hypertension are unknown, specific therapy for hypertensive disease is obviously not possible. Furthermore, there is no evidence that any form of therapy used today actually prolongs life for hypertensive patients. The great controversy regarding the treatment of this disease centers about the question of whether the course of the disease is altered by the mere symptomatic lowering of blood pressure through either medical or surgical measures.

If essential hypertension is regarded as a generalized vascular disease rather than as a mere elevation of the blood pressure, then little is known about the disease except that it consists of an increased constriction of the arterioles and the consequences of such constriction. It is not known whether this arteriolar narrowing is due chiefly or exclusively to sympathetic vasomotor constriction, to intrinsic spasm initiated by humoral or metabolic agents, or to an exaggerated response to normally circulating constrictor substances. Secondary structural changes may intensify the narrowing.

Furthermore, it is not known whether (or to what extent) the elevation of blood pressure is responsible for the symptoms and complications of essential hypertension. It is highly probable that the cardiac and cerebral complications which are the most frequent causes of death are due chiefly to atherosclerosis and that the elevated blood pressure is only a secondary contributory factor. In addition, many symptoms that appear in uncomplicated essential hypertension do not differ from those frequently seen in normotensive individuals with emotional disturbances.

On the other hand, the elevated blood pressure appears to be a significant, if not the major, factor in the symptomatology and complications associated with that form of essential hypertension which is called the accelerated or malignant phase. Despite occasional exceptions, clinical experience indicates that at the same time the diastolic blood pressure rises to 140 mm. or more, there develops a high incidence of malignant nephrosclerosis with necrosis of arterioles, uremia, and the characteristic occipital headaches and visual disturbances (due to retinal hemorrhages and exudates).

With these considerations in mind, the physician must then decide whether he is to treat an elevated blood pressure or a disease called essential hypertension. In the cases of malignant hypertension, the reduction in blood pressure is an important therapeutic objective, and the use of specific agents or techniques designed to lower blood pressure is therefore indicated.

In all other groups of essential hypertension there is an uncertainty as to the effect of elevated blood pressure in producing the symptoms and complications. There is therefore a less definite foundation for the use of antihypertensive measures in such patients. However, the need for reducing blood pressure even in such cases may be explained by the evidence that elevation in blood pressure accelerates the development of coronary or cerebral atherosclerosis and also adds to the mechanical work of the heart. Perhaps lowering the blood pressure in the more benign group of the hypertensive patients will prevent the onset of the more malignant or accelerated phase.

General Treatment in Presymptomatic Stage

Before considering specific antihypertensive measures, the general treatment of hypertension should be considered. In the presymptomatic stage there is no reason to make the patient overconscious of his blood pressure or to cause his life to become one of anxiety and semi-invalidism. A fairly free rein should be allowed the patient so that before the onset of hypertensive complications his life may be full, enjoyable, and useful. The most important therapeutic principle at this time is the prevention of anxiety. While anxiety is not believed to influence the hypertensive disease itself, it does make a difference in the patient's outlook on life. When telling the patient about his affliction, the doctor should refer to the disease as a blood pressure "tendency" or as high blood pressure.

The doctor should explain to the patient, in simple terms, how pressure produces the flow of blood through the body; how pressure rises and falls as a result of emotion, exercise, and change of posture; and how, if it did not change, the patient would faint every time he ran up stairs or got out of bed. The doctor should point out the fallacy of the concept that a stroke will occur when pressure rises, since strokes occur as often in bed as when the patient is ambulatory.

The fact can be emphasized that the rise or fall of blood pressure from one visit to the next is of absolutely no significance to the physician. The important thing is what the blood pressure is doing to the patient; therefore eyes, heart, and urine are examined at periodic intervals. The chronic aspect of the process should be explained and the patient told that although trouble may eventually occur, it is impossible to tell whether it will be 10 or more years from this time. There is absolutely no need to mention possible serious complications; the good physician will do the worrying and let the patient know when the time comes to alter his living activities.

After a complete hypertensive work-up is made and baseline data on the patient recorded, he is advised to make one or

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two return visits to learn of the clinical and laboratory findings. After this, periodic visits for check-up should not be more frequent than once or twice a year and should always serve as a source of reassurance to the patient.

At this early stage of the disease there is no need for dietary restriction unless the patient is obese. In such cases, weight reduction is desirable, for it is often associated with a fall in blood pressure. But in some studies the results are unpredictable, inconstant, and rarely impressive. The possible value of low-calory, low-fat, and presumably low-cholesterol diets to the hypertensive patient may lie in their ability to retard the atherosclerotic complications associated with hypertension. In addition, weight reduction may increase the cardiac reserve in patients with early congestive heart failure.

Neither is there any need for surgery or radical change in the patient's daily activities. If he is young, he should follow the activity pattern of his more slowly moving companions, avoiding only the peak loads of exercise and avoiding intemperance. It is well for the patient to refrain from group competition in such sports as basketball, football, soccer, and crew, in which the desire not to let down his teammates may force him to excesses of exertion Tennis and swimming, as well as baseball, are permitted. As a matter of fact, more harm than good will result from imposing restrictions which make the patient's pattern of life unnatural. In the middle and older age groups, the way of life need not be changed at all, since they have already slowed down.

Excesses, in general, should be avoided, especially in regard to tobacco, alcohol, coffee and tea, late hours, long working hours, and overeating. Vacations for these people are an absolute necessity.

A great deal has been written about the emotional aspects of the patient's life, but psychotherapy for the control of the hypertensive process has been unrewarding. Suffice to say, these patients should not be pampered, restricted, put on diets, or overtreated during the asymptomatic phase of the disease. *Watchful neglect* makes life full and worth living for these patients.

Treatment During the Symptomatic Stage

Headaches may be relieved by elevation of the head of the bed, a cup of strong coffee or tea on arising, simple analgesics, such as aspirin or various commercial varieties of pills containing mixtures of aspirin, acetophenetidin, and caffeine. Morphine and its derivatives should be avoided because they may be habit-forming in those whose symptoms persist for years. Intractable headaches sometimes yield to lumbar punctures and usually to sympathectomy. For the nervous, high-strung person, chloral hydrate or elixir of sodium bromide may be adequate for sedation.

Specific Antihypertensive Measures

As has already been noted, the application of specific antihypertensive measures is based on the assumption that the underlying disease process will either become quiescent or recede once blood pressure falls to or approaches normal. Whether such an assumption is justified still remains to be proved. Specific antihypertensive measures include the use of a rice diet and other low-sodium diets, the antipressor or hypotensive drugs, sympathectomy, and bilateral adrenalectomy.

Rice and Other Low-Sodium Diets

Recognition of the possible relationship of the sodium ion to hypertension first led physicians to prescribe low-sodium diets over 45 years ago; they have recently regained popularity. The diet contains, preferably, less than 200 mg. and not more than 500 mg. of sodium daily. Adherence to the diet is checked by urinary sodium, which should total less than 500 mg. in 24 hours.

Kempner recommended the so-called rice diet, which consists of 300 Gm. of rice, 20 Gm. of nonanimal protein, 5 Gm. of fat, 150 mg. sodium, 200 calories of carbohydrates in the form of fruits or fruit juices, 1 liter of fluid, and vitamin supplements daily. He noted a significant reduction in blood pressure, decrease in the size of the heart, the disappearance of electrocardiographic abnormalities, and improvement or disappearance of retinal abnormalities with this diet. There was also an impressive increase in survival time during a five-year follow-up study.

It has now been amply demonstrated that the merit of the Kempner rice-fruit diet depends on its very low sodium content; low-sodium diets of more palatable and varied composition are equally effective in reducing high blood pressure. Today it is generally conceded that the rice diet is an impractical method for the treatment of hypertension; it has become less popular with the advent of hypotensive drugs. And it is even difficult to keep patients on well-balanced sodium diets over long periods.

To reduce the unpalatability of extremely low sodium diets, cation-exchange resins have been introduced. While cation-exchange resin therapy in combination with low sodium intake is occasionally followed by dramatic improvement in patients whose hypertension had not responded to sympathectomy, the unpalatability of the bulk, its expense, and other unpleasant features associated with resin therapy have negated its advantages.

The rigorously low sodium diet does not appear to be indicated for the mild or moderate form of hypertension. However, in the malignant phase of hypertension, this form of therapy may be necessary for the patient who cannot tolerate the more powerful antipressor drugs and who prefers to try medical therapy before considering sympathectomy. The low-sodium diet may be preferable or safer than the strong hypotensive drugs for patients with cerebral, coronary, or renal insufficiency in whom sudden reduction in blood pressure may involve some risk. Finally, it is possible that low-sodium treatment of hypertension has a theoretical advantage over the use of hypotensive drugs and sympathectomy in that it may more directly affect the intrinsic arteriolar resistance which appears to be the basic abnormality in essential hypertension.

Antihypertensive Drugs

Many new depressor drugs have recently been introduced and are being used in the treatment of hypertension. The ideal hypotensive drug should produce a prolonged fall of blood pressure in a large proportion of patients through a generalized peripheral vasodilatation. But, to date, no such ideal drug exists. Drugs which have received extensive study in the last few years, the mechanism of their actions, and the major preparations found in each group are discussed below.

Adrenergic Blocking Agents. This group of drugs includes such agents as Dibenzylene (phenoxybenzamine). These drugs act by blocking adrenergic impulses, thus interfering with response to sympathetic stimulation and preventing peripheral vasoconstriction.

Ganglionic Blocking Agents. This group includes methonium compounds, such as hexamethonium, pentolinium (Ansolysen), chlorisondamine (Ecolid), and mecamylamine (Inversine). These drugs are potent agents which suppress or inhibit both sympathetic and parasympathetic impulses by blocking the ganglia of the autonomic nervous system. Arteriolar constriction thus is diminished, the peripheral resistance is reduced, and blood pressure is lowered. Orthostatic reduction in blood pressure is especially marked, and orthostatic hypotension may result from the use of these drugs.

Central-Acting Inhibitors. This group of drugs includes the 1-hydrazinophthalazine derivatives such as hydralazine HCl (Apresoline). Their methods of action are uncertain, but these drugs appear to inhibit humoral pressor agents and may otherwise inhibit sympathetic vasoconstrictor impulses from the central nervous system, thereby reducing the blood pressure. They may also act directly on the smooth muscle of blood vessels to release tone. These drugs cause tachycardia and significantly increase cardiac output. Renal blood flow is increased, and there may be a selective action on the renal vessels independent of the increase in cardiac output.

Activators of Afferent Reflex Areas. This group of drugs includes the Veratrum compounds, which are obtained from the roots of Veratrum album and Veratrum viride and composed largely of alkaloid esters yielding alkamines. The preparation veratvis is the crude root. Virgitryl and Veriloid are purified mixed alkaloids of Veratrum viride. Pure crystalline alkaloids—proveratrine A and B—obtained from the Veratrum album are marketed as Provell Maleate and as Veralba. Cryptenamine is an alkaloid fraction of Veratrum viride supplied commercially as Unitensen-R.

The Veratrum drugs reduce the blood pressure of the hypertensive individual by reflex depression of the carotid sinus and consequent inhibition of its effector vasoconstrictor nerves. The drugs produce cardiac slowing by a reflex mediated through the vagal cardio-inhibitory nerve. The receptor sites for the action of these drugs may be in the left ventricle, coronary, and pulmonary arteries. The decline in blood pressure is associated with a reduction in the peripheral resistance, which is evenly distributed through the vascular system, and with a moderate decline in cardiac output.

Drugs of Unknown or Mixed Action. Rauwolfia Serpentina is representative of this group. The root of this Indian plant is the source of a number of drugs which lower the blood pressure and produce bradycardia. Raudixin is a commercial preparation of the powered root; Rauwiloid is the alseroxylon fraction that contains active alkaloids. Another drug derived from this root is Reserpine, a purified crystalline extract available commercially as Serpasil.

The site and method of action of such drugs are somewhat uncertain, although it is presumed the drugs act on the hypothalamus, thereby causing central sympathetic inhibition and perhaps parasympathetic stimulation. They diminish reflex motor responses, but may also act directly on the blood vessels, independently of the nerve supply. Reserpine reduces sympathetic activity by blocking afferent impulses at some central site, but does not directly depress diencephalic centers. As a result, there is a fall in blood pressure and bradycardia occurs. A remarkable and useful action is its so-called tranquilizing effect, whereby it lessens irritability to outside stimuli.

Choice of Drug

The decision to employ a hypotensive drug and the choice of drugs depend in large measure on the evaluation of the severity and type of hypertension and the presence (or absence) of complications. The choice of hypotensive drugs will be discussed with reference to the following groups of patients:

Mild Benign Hypertension. In a patient with the systolic blood pressure under 200 mm. and a diastolic of 110 mm. or less, there is usually no need to use hypotensive drugs. Reassurance, mild sedatives, and weight reduction—if necessary—constitute adequate therapy. In cases of mild hypertension accompanied by symptoms, the preparations of Rauwolfia Serpentina have come to be widely used because they offer the benefits of mild sedation, while at the same time being capable of reducing blood pressure in a fair percentage of cases.

Moderate and Severe Benign Hypertension. These patients have systolic blood pressures ranging from 200 to 250 mm. and diastolic pressures from 110 to 120 mm., but no fundus changes characteristic of malignant hypertension. The first drug usually chosen is a preparation of Rauwolfia because it is associated with a low incidence of side effects. If this preparation proves ineffective after several weeks, a preparation of Veratrum is added; a preparation of hydralazine may later be added or substituted for Veratrum if the latter is not well tolerated. If these drugs alone, or in combination, are ineffective, the ganglionic blocking agents such as pentolinium, Ecolid, and Inversine are used. The administration of these ganglionic blocking agents is more complicated, requires more careful observation, and involves greater risk than other antihypertensives mentioned.

Malignant Phase of Hypertension. There is an urgent need for prompt reduction in blood pressure in patients in this phase. Hypotensive drugs are now preferred to low-sodium or rice diets and sympathectomy; these drugs must be administered before there is severe azotemia or uremia. Those drugs commonly used are the ganglionic blocking agents—pentolinium, Ecolid, or Inversine. As a rule, they are combined with Rauwolfia or hydralazine, thus making them more effective, enabling smaller doses of the ganglionic blocking agents to be used, and neutralizing some of the side actions of these drugs.

If the hypotensive drugs cannot be tolerated or are ineffective in a particular patient, a low-sodium diet (200 mg. or less) is used in combination with a Rauwolfia preparation, either alone or together with Veratrum in maximally tolerated doses. If these measures are ineffective, sympathectomy may be advised. If sympathectomy proves useless, the various hypotensive drug programs are repeated because they are sometimes effective after the operation, even though the patient was unresponsive to them before.

The use of hypotensive agents has apparently reduced the mortality rate of patients with malignant hypertension from 85-100 per cent to 45-55 per cent over a period of 18 months to three years.

Nevertheless, many investigators caution against using hypotensive drugs for patients with renal insufficiency.

Benign Forms of Hypertension with Complications. This concerns chiefly the cases of mild, moderate, or severe benign hypertension complicated by angina pectoris or coronary thrombosis, cerebral infarction or insufficiency due to atherosclerosis or cases complicated by uremia. When the complication dominates the clinical picture, it is the complication that must be treated. Reduction of blood pressure may be beneficial when the hypertension is complicated by congestive heart failure or by recurrent or threatening cerebral complications. Hydralazine (Apresoline) is contraindicated because it increases the cardiac output and induces a strain on the heart.

Sudden and drastic reductions in blood pressure are not desirable in patients with hypertension who show evidence of a low coronary reserve or coronary insufficiency.

Acute Hypertensive Crises. The hypotensive drugs are indicated in the treatment of acute hypertensive encephalopathy or hypertensive crises which are usually characterized by symptoms caused by sudden elevation in the blood pressure and cerebral edema.

While it is sometimes possible to confuse these with a cerebral infarct or hemorrhage, such a mistake is very unlikely if due care is paid to history and findings. In such cases the most desirable form of treatment appears to be the intravenous administration of a Veratrum alkaloid or the parenteral use of the ganglionic blocking agents. Reserpine may be effective when administered parenterally.

Surgical Treatment of Hypertension. More or less extensive sympathectomies have been performed to eliminate or reduce the neural component responsible for increased splanchnic arteriolar vasoconstriction and hypertension. These operations probably reduce arteriolar constriction by diminishing normal sympathetic tone without affecting the pathologically increased intrinsic arteriolar tone. Beneficial results have been reported in a majority of patients who have undergone sympathectomy.

It appears, however, that after having been employed for about 20 years, sympathectomy is rapidly falling into disuse. This clearly indicates that the surgical procedure of sympathectomy, despite its relatively low mortality, is regarded as a formidable experience in comparison with available medical regimens, and that the results obtained by the latter are regarded as being at least as satisfactory as those obtained with sympathectomy.

Bilateral Adrenalectomy. This extremely radical form of therapy for hypertension is rarely performed, and then only when all other methods of control fail. The procedure is regarded as experimental, its use dependent on observations following bilateral adrenalectomy and followed by prolonged repression of vascular disturbances.

In summary then, we find that medicine has progressed considerably in the evaluation of symptoms of hypertensive disease, but etiology and pathogenesis of the disease remain medical dilemmas. This is an area rich in opportunity for original research.

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THE DYNAMICS OF HUMAN RELATIONSHIPS

Let's talk it over

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THIS article will conclude the last one based on excerpts from the recordings of the discussion of Eleanor Page Bowen's workshop presentation, "Teaching–Learning–Evaluation: One Gestalt."

The afternoon general session had opened with questions from five subgroups which had met during the second half of the morning session. A representative from each of these groups was seated at a round table with Miss Bowen, who clarified the nebulous points with regard to establishing nursing school objectives as a basis for self-evaluation of students and instructors. The discussion continued with a consideration of evaluation criteria, the grading of students as an evaluation measure, the meaning of a normal curve of distribution, the ethical use of confidential information, and the meaning of a gestalt.

Participant A: What can we in a diploma school of nursing do in order to meet accreditation criteria of the National League for Nursing with regard to separating nursing education and nursing service functions? If the clinical instructor is supposed to be responsible for student evaluations what, then, is the role of the head nurse in this matter?

Participant B: Shouldn't we consider the meaning of the League's accreditation criteria? I understood that these were intended to be based on the philosophy of a school of nursing. Why, then, do we complain about what the League expects of us? Aren't we the ones to determine our own philosophy and objectives and then show how we are achieving them?

Miss Bowen: It would seem that our concern about the dichotomy of service and education belies our belief in team relationships and interdependence. Evaluation criteria need to be based on the realities in nursing. An impossible task confronts us when, for example, we are expected to have a ratio of one clinical instructor for every six students and are unable to find nurses for such positions or lack an adequate budget to employ them.

Participant C: Like Miss A, I am interested in the role of the head nurse. I have been expected to evaluate students even though I did not anticipate this when I accepted the position of head nurse. I am not as sure about myself as I would like to be regarding what to put down on a record.

Miss Bowen: In practice we find some feel that student evaluations should be made only by the clinical instructor, while others feel that the head nurse is the key person.

Participant D: I once worked in a school well staffed by clinical instructors; each instructor conferred with the head nurse about the students and used information gained from these conferences as the basis for the evaluations.

Miss Bowen: If we agree that an evaluation should be a record of a student's progress toward achieving established objectives, then both the instructor and the head nurse need to be aware of these objectives and even help in shaping them. In addition, the head nurse could more readily make her contribution when a few relevant points are identified for her to observe, such as how a student reacts to tension or shows ability to solve problems.

An honest evaluation of students depends on properly orienting the head nurse. In some instances a check list is used of vague terms to describe traits, such as dependability, sense of responsibility, or reliability. This is a rather ineffective instrument for communicating the qualities of a person. On the other hand, a written or verbal description of a student's actions is more readily understood.

Grading is also a basis for evaluation, that is, a letter or percentage grade gives us a measure of a student's ability in a given area. Our evaluation is further determined by an accepted standard. However, a progressive set of standards is necessary as a basis for assessing the growth and development of a student throughout the entire period of her preparation. We should not expect a first-year student to measure up to what is expected of a graduate.

A three- or five-point scale is still generally used to check the evaluator's impressions of a student. However, this kind of rating needs to be supplemented, or replaced, by a descriptive statement. It is difficult to determine the meaning of "good" or "average" when used to describe dependability or resourcefulness. But a descriptive statement could tell us about how a student behaved in a frustrating situation with a particularly difficult patient or on a day when the nursing staff was depleted.

A student's grasp of information taught in courses can be determined by examinations, but her skill and emotional stability are not readily communicated by percentage or letter ratings. It is a questionable practice to average theory and practice grades according to numerical or letter ratings. This does not help us to identify the strengths and limitations of a student's intellect, emotions, and practical skills. However, several anecdotical records can reveal tendencies to certain types of behavior upon which to base an evaluation.

Participant E: Could you tell us something about the use of a normal curve in grading?

Miss Bowen: A normal curve is a theoretical percentile distribution of variations ranging from highest to lowest in an undifferentiated cross section of a relatively large sample of a population—probably not less than a thousand persons. The improper use of a so-called normal curve of distribution in grading a small class can be a serious injustice to students.

Even though the composition of students differs from group to group, the chances are that selection devices have assured the elimination of those who might have fallen in the lowest percentile on a normal curve. So you can scarcely determine in advance that a given percentage of students may fail an examination. There are a number of other reasons besides variations in student composition that account for differences in class achievement; these include instructional stability, grading standards, and methodology. We are all aware of the different values of similar ratings from school to school.

Participant E: Then why do we bother about grades?

Miss Bowen: Some schools have experimented with the elimination of grades and merely passed or failed the student. They then found that this seemed to lessen the motivation of students in putting forth their best efforts. Since grades seem to be a necessary evil, we need to be able to grade as fairly as possible by setting up some basis for determining the lowest passing grade and then distributing the grades according to a class range. However, such subjects as drugs and solutions require exact answers to questions and here your scoring needs to be based on a predetermined standard of the number of questions you expect to have correctly answered.

Participant F: Will you discuss the question on the teacher's social relationships with the students outside of the classroom and work situations?

Miss Bowen: I have already given you my opinion about the necessity for the teacher to know the student as an individual. A student generally seeks guidance and counsel only from someone she respects, and each gets to know the other in a different light in a social setting where mutual trust and respect may be fostered through informal relationships. Only insecure instructors fear the loss of an advantage when outside a position of authority.

Participant G: Is this social relationship to be on an individual basis or through group action as in luncheons and teas? I can't quite go along with the idea of an intimate social relationship.

Miss Bowen: We are rightly concerned about what might happen by encouraging a crush of the young student on the instructor. However, when this does happen we might regard the evidence of a student's insecurity and ask ourselves if she needs a mother or big sister figure for a while. If we view this attachment as an impersonal force and not a feeling of our own ego, we can help her to outgrow an immature phase. But if the student is squelched, she is likely to be hindered in outgrowing this phase. Crushes are not encouraged, but they do occur and then need to be constructively handled.

Participant H: How can they be constructively handled?

Miss Bowen: That depends on the situation. A mature person with warmth and understanding is not afraid of her feelings for a student. Such a person talks to the student about this problem as she would about any other phase of emotional insecurity.

Participant I: Do you think a student is as likely to take a personal problem to an instructor as to someone who is not associated with her profession?

Miss Bowen: We need to distinguish between counseling a student about her work and counseling her on a personal problem. There is no single answer to the question with regard to the student who shares a confidence about something she has done to her own discredit. It will depend on whether or not her actions affect the reputation of the school. If they do, then a highly regarded instructor is in a favorable position to encourage a student to report her actions to the proper authorities, no matter how painful this might be. The pain has already been eased by the first sharing, and further action becomes a constructive learning experience.

Participant J: Will you tell us what bearing conformity or lack of it has in such matters?

Miss Bowen: All of us are expected to conform in certain ways. Our concern is probably about those instances where we might have used our initiative to do something creative. As teachers we need to be alert to a common tendency toward rigidity in expecting students to do exactly as we say. We can encourage growth in accepting responsibility by teaching according to an acceptable method and then also welcoming suggestions for improvement.

A real problem exists in the necessity for conforming without stifling freedom of self-expression. Certain limits should be set for students during the time they are learning and growing in their clinical competence with patients. Inevitable mistakes along the way can become learning experiences when we assess the reasons rather than fix the blame for them.

Participant K: A question was asked about how we can motivate ourselves first so that we may motivate the students. Some nurses are in supervisory or teaching positions in which they feel inadequate, and this is reflected in the students who are said to lack proper motivation. Is this not a problem of faculty motivation?

Miss Bowen: I have found that students tend to keep me motivated. So we will need to see the reasons for the kind of person you mention. Why is she in a position evidently unsuited to her? Was she assigned to it because no one else was available? Was anything done to lessen her insecurity by offering opportunities for more preparation or guidance on the job?

Participant L: Can any of us really motivate another person? It seems as though all we can do is to provide a situation where a student is free to develop.

Miss Bowen: I have been motivated by those people who had faith in me and whom I didn't want to let down. We can motivate others by what we do and say to them. But we can also stifle their self-expression when we insist that their interests coincide with our own.

Participant M: It seems as though instructors sometimes stereotype students and then try to make them fit into their preconceptions of them. Then if a student fails to respond according to an expectation of her, she is evaluated as being disinterested.

Participant N: I wonder if you could tell us what you had in mind about the meaning of the word "gestalt"? I have spoekn about this with members of my group and still find it difficult to grasp the meaning of the word.

Miss Bowen: Let me draw a circle for you on the blackboard. My experience with students has shown their tendencies to various answers indicated by the alphabet letter O, or a numerical zero. But now see how more readily we agree on the meaning of the circle by placing before it the numeral 2 or the letter S.

The word "gestalt" comes from the German, meaning "form." Gestalt psychology is the theory that physical, psychological, and biological events do not occur through the summation of separate elements, but through formed patterns of integrated units which function singly or in interrelation. Each pattern is called a gestalt. Hence, in our discussions on forming objectives, evaluation criteria, and self-evaluations, we did not consider teaching, learning, and evaluation as separate entities. These functions were interrelated as a whole in clarifying a specific concept of yours and each emergent pattern was a gestalt.

A basic element of the American dream is the assumption that every individual has the right to an education. But this tenet is limited by some practical qualifications. A noted educator and clinical psychologist, in an address presented at the 1958 Workshop on the Dynamics of Teaching, raised certain questions about general education problems and related them to nursing education.

EDUCATION — the Dream and the Reality

EDUCATION has suddenly become a dominant topic of interest and discussion among the American people. In part this derives from the increasing realization that primary, secondary, and higher education in this country have been undergoing a continuous degradation for some years past, as witnessed by the fact that the problem of illiteracy is no longer confined to those unfortunates who have been deprived of the opportunity of attending school, but has spread among those individuals who have had the supposed benefits of primary and secondary schooling.

In part it is the result of the sudden threat to our national security, and I would unhesitatingly call this threat, which comes from recent Russian technological advances, economic as well as military. In any case, there has been an increasingly wide discussion of American education in the public press, a discussion marked more by the ventilation of emotion than by the calm, objective evaluation of basic educational goals and by the rational consideration of efficient means for their attainment.

When a public discussion is as fraught with bias, prejudice, and emotional catharsis as is the current discussion of education, it behooves any audience to weigh carefully the purpose, role, and justification of each person discussing the topic. My own purpose here is not to spell out the goals of nursing education authoritatively and to define pontifically the means of reaching them, but rather to raise certain problems basic to education in general, to indicate some of their implications in nursing education in particular, and to challenge the nursing profession itself to find its own solutions. My role is that of a friendly commentator speaking from the sidelines. My justification, such as it is, comes from 30 years of participation in education, both as teacher and as administrator, and my present participation as co-director of a Northwestern University-Carnegie Corporation project to bring the techniques and findings of basic experimental psychology back into closer liaison with educational practice. Most important of all, perhaps, is my membership in a profession — clinical psychology — which has been working through many of the same problems of professionalization that currently are besetting the nursing profession, and that in the performance of its service functions often must work closely with the nurse, both educationally and clinically. It is from this background that the following remarks stem.

Assumptions

In any discussion there always are some latent, underlying assumptions which must be brought out into the light if the problem is to be clarified. Education is no exception, and our current attitude toward it is determined by many implicit assumptions that need re-examination if we are to understand the problem. Let me illustrate.

Basic to the American dream is a firm belief that every individual is entitled to an education and that it is the duty of society to provide him with the opportunity of getting it. With this fundamental tenet of democracy we cannot quarrel. If we view the matter realistically, however, we must see that this right of the individual to an education is limited by two very practical qualifications—if he can get it, and if he is capable of benefiting by it. The first qualification raises all the thorny problems of economic and environmental opportunity. It can be solved, nevertheless, and we have made tremendous strides during this century toward removing it. Our concern here is with the second qualification—that an individual's right to an education is limited by his capacity to absorb it. This fundamental truth must be faced in building any realistic structure for public education.

The American public, however, seldom is willing to face this issue squarely. Any limitation on opportunity in a democracy has an unpleasant, undemocratic appearance and is sure to arouse a wave of opposition. Nevertheless, the fact remains that the level of education that any individual can benefit from is dependent upon his intellectual ability, and individuals differ tremendously in their capacities to learn.

The problem is perhaps not so pressing in primary education where, except for outright mental deficiency, the difficulties raised are ones of differential rate of progress rather than absolute ceiling of ability. But the problem of the upper limit of potential begins to raise itself in secondary education and becomes crucial in higher education. The assumption that any young person can benefit from four years of college is a fallacious one and is in large part responsible for the increasing degradation of our system of higher education. For as more and more people seek admission to college irrespective of their ability to profit by it, the level of ability among the student body drops, and of necessity the academic offering is diluted to meet this lowered ability. The result is an inevitable downgrading of higher education.

The Answer

Selection is the only answer, and it can be used effectively only after society accepts the unpalatable fact that not everyone can benefit from higher education. Granted, selection in the past has relied too heavily on the unfair

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criterion of economic potential or ability to pay; granted, our present technical methods, such as psychological testing, are at best imperfect (although the logic behind their construction is often superior to that on which the arguments of their critics are based). Nevertheless, some form of selection is going to be necessary if higher education as we know it is to be preserved.

This problem of ability and selection has been a constant one for the professions and it will be an increasingly important one for nursing. As the complexity and responsibility of nursing duties increase, the available pool of potential nurses will decrease. The proportion of people capable of assuming nursing duties will become smaller and smaller. You will be faced by the alternatives of fewer but better nurses, or more but poorer ones, and the history of professional advancement has always demanded the choice of the first.

There are several other implicit assumptions underlying the usual approach to education that unless made explicit and carefully worked through may lead to confusion and frustration. Let us look at three of these:

► The first assumption is that the desired content for any curriculum is known and available. This is the problem of what should be taught, and it entails such thorny details as the availability of appropriate texts and other teaching materials. Our main concern here derives from what seems to me to be the major issue facing nursing education today: Until the profession decides what a nurse should be, it will be impossible to construct any perfect program for training the nurse.

► The second assumption maintains that efficient means of transmitting the desired content are at hand, that we know how best to train so that we may achieve our goals. Actually the technological practices of American education are based upon some very shaky, very limited, and often completely inadequate objective evidence. Our educational procedures unfortunately have developed well in advance of our scientific knowledge of human behavior.

As a result, the behavioral sciences have been confronted with an already firmly established educational system before they have yet had time to gather the adequate behavioral data necessary for the foundation of any enduring, efficient program for educational training. Consequently, the meager objective data that are available from psychology and the other behavioral sciences have too often been subject to theoretical distortions in order to rationalize an already established program, or at best have been subject to attenuable inference and extrapolation that have produced unwarranted conclusions, unjustifiable under any rigorous interpretation of the scanty evidence available.

I think it is fair to say that with the exception of some current military research in the training area, the best research brains and research resources of experimental psychology are not being utilized in the field of education. There are, of course, some exceptions, but in general the situation resembles the early days in the development of scientific medicine when the medical profession was still struggling to free itself from the dominance of blind custom and precedent and place its healing techniques upon a sound, experimentally demonstrable basis. Under the circumstances you should approach any proposals for educational practice with a healthy though tolerant skepticism.

► The final assumption we shall mention here is that capable people are available to benefit from training. We have already touched on this problem in discussing selection. We shall return to it later in discussing recruitment, for the quality of the manpower pool available for training will inexorably condition any program of nursing education.

Stated simply and tersely, our problems can be reduced to what to teach, how to teach it, and to whom to teach it. Yet the simplicity of this statement covers a terrifying complexity of specific factors, all of which interact to increase the intricacy of the total pattern. That you and I are willing to face these confusions and are able to hope for some solutions is a testament to human courage and to that blind drive toward an increasing skill in coping with reality that has characterized the development of the human organism.

The answers can only be reached by a careful, laborious, and completely objective analysis of the realities of the situation. Unfortunately, normal growth with its attendant change adds to our difficulties by demanding that such evaluation be a continuing process. The assessment of professional education is a continuing process and it is never done.

The growth or developmental process, moreover, is not constant. The rate of growth is seldom even or uniform, but is marked instead by a succession of relatively stable periods alternating with periods of drastic change. The problems of nursing education today are complicated by the fact that the nursing profession currently is undergoing one of these periods of drastic change, marked by a pronounced upgrading of its duties and responsibilities. This upgrading has two important consequences for nursing: (1) the addition of duties of increasing complexity and difficulty with attendant increased responsibility, and (2) the release of some lower-level duties entailing less responsibility, and the delegation of these duties to ancillary groups of lesser professional status.

This upgrading is not a problem specific to the nursing profession, but is reflected in all the scientific disciplines as a consequence of the tremendously accelerating accumulation of scientific knowledge in this century. In a paper titled "Manpower Aspects of Higher Education and Technology," read at the Conference on Engineering and Scientific Education—Foundation of National Strength this year, M. H. Trytten stated that at our present rate of progress the amount of scientific knowledge is doubling every nine years, and the rate is still increasing. One may ask, wryly but with justification, whether it is not possible that normal, everyday living, the ordinary daily adjustment of the average citizen to the demands of his environment, is not itself being upgraded to the status of a profession.

You are all familiar with the results of this acceleration and proliferation of knowledge within the field of medicine, with the piling up of specialty upon specialty with superspecialties arising beyond this, and the consequent confusing problems that face medical education as a result—the increasing temporal demands of medical training, the crowding in of knowledge from such ancillary disciplines as psychology, sociology, and anthropology, and the dangerous crowding out of the humanities.

The ultimate *reductio ad absurdem* may well be the development of the superspecialist who concentrates on the circulatory disorders of the little finger of the left hand, only to suffer the sudden shattering disillusionment of realizing that such disorders cannot be understood and controlled in isolation from the total man. These are problems that nursing is beginning to face today and which will fall upon you in their

full devastating force tomorrow.

Under such circumstances the question of what is a nurse—which must be settled before you tackle the problem of how to train one—is not an easy one to answer. It is further complicated by a basic conflict within nursing itself. Based upon an early philosophy of bedside care involving intimate personal interaction with patients, nursing now finds such direct patient care crowded out by administration, teaching, research, and even medical functions previously delegated to the doctor but now out of necessity placed in the hands of the nurse. Nursing is facing this problem but has by no means worked it through as yet. Witness the emotion that is generated in public meetings whenever this is discussed, emotion that testifies to the intensity of the personal feeling that is involved in this conflict between the classic role drilled into you since early training and the changed role forced upon you by contemporary demands.

The answer may well be that you will find some soothing compromise. My own suspicion is that ultimately you will abandon the old role and learn to live with the new. In this I am supported by some findings in a recent book, *Change and Dilemma in the Nursing Profession*, edited by Reissman and Rohrer.[1] This is a most stimulating and provocative treatise, based as it is upon objective data obtained in a comprehensive study of Charity Hospital in New Orleans, La. They find that even those nurses who bewail the lack of opportunity for bedside contact with the patients under their care actually fail to take advantage of the opportunities to provide bedside care when such opportunities arise and time permits. Whatever your solution to this conflict may be, until it is settled and until the professional role of the nurse is clearly defined and accepted, emotionally as well as intellectually, by the profession, it will be impossible to answer the question of what to teach.

The process of downgrading and releasing some functions to other workers also raises problems of maintaining status hierarchies, the stratification of duties, authoritative control of subordinate ancillary groups, responsibility for educational functions, etc. Important as these may be, however, they are tangential to educational problems and are overshadowed at present by today's primary necessity of first defining and then accepting the role of professional nursing itself.

In any case, whatever the final definition of your role may be, there are other broad problems involving what to teach that I am sure will remain with you, although we must remember that what, how, and whom to teach are all related, interacting variables which determine one another rather than operate independently. No educator observing your curricular discussions from the sidelines can help but be impressed, if not overwhelmed, by the diversity of subject matter proposed. Your own program for this conference is an example, suggesting as it does "the nature of communication; the dynamics of interpersonal reactions; the dynamics of group interactions; the evaluation of progress in learning." The absorption of all this in five days may, I suspect, produce as much educational indigestion as enlightenment.

This tremendous diversity in your goals, with its complexity of demands upon training, is nowhere better illustrated than in a series of papers in the November 1957 issue of *Military Medicine*. The writers, Mary Redmond, Inez Haynes, Elizabeth Feeney, and Louise Anderson, are prominent figures in contemporary nursing and have earned the right to speak for their profession. All accept the basic necessity of developing the nurse-patient relationship to give a fine quality of nursing care intended to meet the nursing needs of all patients, but Miss Redmond adds the need for specialization of the nurse, pointing out the need "to perform expert nursing in a particular clinical setting in which medical specialization makes special demands on her knowledge and skill in giving care to individual patients who have particular disease conditions."[2]

Miss Haynes adds, "As important as it is for the nurse administrator to be a competent professional nurse, she should also have preparation and experience in the principles of administration."[3] In her article, Miss Feeney surveys teaching needs within the structure of nursing education, as well as the on-the-job instruction of the patient in self-care and the education of the family in home care for the patient leaving the hospital. She summarizes, "In addition to the principles and methods of teaching and the laws of learning, the professional nurse now needed to know communication skills, interpersonal relations, group dynamics, problem-solving techniques, and qualities of leadership."[4]

To all this Miss Anderson adds the heavy burden of research by saying, "Our profession will not really come of age until we have added to the sum total of scientific knowledge."[5] One is tempted to add with friendly cynicism, "All this and living too."

Still Young

You are young as a profession. You have the strength, the ambition, and the ideals of youth. But in your enthusiasm, is it not possible you have set your goals too high, desirable as they may be? The picture often reminds me of the situation some 15 years ago in my own young profession of clinical psychology when we envisaged the ideal clinical psychologist as thoroughly versed in basic experimental psychology, in the specialties of social, developmental, personality, and abnormal psychology, in the supporting disciplines of sociology, anthropology, biology, psychiatry, etc. All these were to be smoothly harmonized by a broadening contact with art, literature, and music, and tempered into a well-functioning clinical instrument by a practical internship experience in some institutional setting. The ideal foundered on the temporal limitations of a four-year graduate training program which already presumes four years of undergraduate liberal arts training.

The mistake we made, that all young professions tend to make, and that I think you may be making, was that we constructed our model in the image of the most accomplished, necessarily older, leaders in our field, embodying all their individual virtues in a single composite and adding a few idealized requirements for good measure. Then we tried to build this ideal model in the modest period of training allowed us, hoping in four years to duplicate the results of 20 or 30 years of working experience, postgraduate training, outside reading, and human living. Needless to say, our educational goals have become more modest and more realistic.

An old friend and colleague of many years standing, Dr. Joseph Bobbitt of the United States Public Health Service, once put it very nicely by saying that we could not hope in any Ph.D. training program to produce a finished clinical psychologist, we could only turn out a young person with the background and potential for becoming one. I suspect you are faced with the same problem, and that, if you attempt to gear your curriculum to an impossible ideal, in the ensuing confusion you may not even attain the possible adequate. Too much, too soon, may give you too little.

The problem of the diversity of content that you wish to cover is further complicated by the diversity in backgrounds and in abilities of the students you are trying to instruct. If one thinks of nursing education not in terms of a few leading schools scattered about the country, but in terms of all the classes being conducted all over the country, in hospitals as well as in colleges and universities; if one also remembers your teaching functions with ancillary groups, such as aides and attendants, I think it fair to say that no other profession has the problem of communication with as wide a range of individual intellectual abilities as does the nursing profession. And it sets definite limits on both what

you can teach and how you can teach it.

Selection will be one answer to this problem, but recruitment may well limit your efforts here, and I suspect this diversity of student ability will be with you for years to come. You may speak blithely of such requirements as a high-school diploma, but this is still a very rough screen at best, as our colleges and universities long ago found out.

Amidst this diversity you are faced with the necessity of making the painful choice between alternatives, since you cannot crowd everything in. In the field of personality and the dynamics of human behavior, should you concentrate on the psychological processes of illness or of normal behavior? Can you understand one without the other? Should you stress patient needs or the processes of leadership, group interaction, decision-making, systems analysis, etc., that underlie so vitally your administrative functions? Should you train in the etiology and dynamics, both physiological and psychological, of illness in order that you may understand it, or should you emphasize descriptively the diagnostic aspects of behavior in order that you may recognize it, observe it accurately, and report upon it helpfully? These all introduce specific problems, however, and my task is to comment on more general issues.

One more aspect of what to teach should be mentioned here. Can you merely take over, unchanged, the content of such related fields as physiology, biology, psychology, sociology, anthropology, etc., or must you select and shape their content to fit the special needs of nursing? Too often in the past the numerous other disciplines involved in your education have not adapted their materials to fit your particular problems, but have narcissistically and egocentrically provided you with an unrealistic content reflecting their own needs and desires. Too often psychologists, sociologists, and anthropologists have concentrated on making you junior psychologists, sociologists, and anthropologists, rather than on making you better nurses. Nor have they always provided the best of their teaching talent, often viewing their educational function with you as a troublesome, distracting burden imposed upon them, rather than as a challenging opportunity for positive, creative endeavor.

As you assume increasing responsibility for your own education and as more and more of you assume the actual teaching obligations involved in it, this situation is being remedied. It is an encouraging sign to see more and more books like Theresa Muller's *The Foundations of Human Behavior* being produced.[6] I would never think of using this as a text in introductory psychology. I would even call it a bad book for this purpose. But a nurse is a nurse and not a psychologist, and it is a good book for nurses. As you increasingly utilize your own specific wisdom and experience in selecting and developing your own teaching materials, and as you increasingly interest the related disciplines in nursing's particular problems, firmly disciplining them into meeting these specific needs, your educational difficulties will be lightened. At present I think you still face a tremendous task of content selection and materials development before what you want to teach is available in readily teachable form.

Rough Empiricism

In discussing some of the basic assumptions underlying the American approach to education I have already cautioned against implicitly assuming that efficient means of transmitting the desired content are at hand. Much has been written about how to teach. Principles and methods abound in both the literature and in educational practice, but these principles and methods are still largely rational, based upon deduction and inference rather than empirically established fact.

Where they are empirical, it is the rough empiricism of human experience rather than the carefully controlled observation derived from experimental settings, such as we usually associate with the scientific method and which contribute the body of fact we call scientific knowledge. Such rough empiricism may lead us to wisdom, and the purely rational approach has made great contributions to knowledge, but in as important a field of human behavior as education we can hope ultimately for something better, a science of education, as well as a science of healing.

Unfortunately, the basis for such a science is as yet meager. When Miss Feeney speaks of the nurse as needing to know "the laws of learning" she is assuming that such laws exist and that their form and significance are adequate for our specific educational purposes. In this she is optimistic, or perhaps merely courteous to a sister discipline. Most experimental psychologists would point out that any laws of learning are as yet few and fragmentary and established on such a general level that their exact application in specific teaching situations is still a dubious and dangerous business fraught with error and (fortunately) not amenable to exact evaluation. In so speaking I am merely speaking frankly, as an experimental psychologist familiar with my field and desperately eager, as many of us are these days, to find relevant materials within my science to guide me in my educational duties.

It is fair to say that, despite the popular assumption to the contrary, psychology in the best scientific sense of the term has not applied its experimental techniques to the practical problems of education with the assiduous concentration that has marked its entry into industry and the military field. We are currently distinguished by our interest in human engineering and our neglect of human education. There are indications that this trend is reversing, and that the future will see applied psychology properly concerned with its essential part in supplying the exact behavioral information necessary for a true science of education. Meanwhile, and for many years to come, educational practice must continue to be derived by rule of thumb and rough trial and error before it can be established on a firm scientific basis.

Inevitably this means that nursing itself will have to devote a fair portion of its energies to devising its own techniques of teaching and to an objective evaluation of the results. In this there is a great opportunity for research, research that will be of value not only to nursing but to education in general. Lacking a large, available, and appropriate body of knowledge in psychology (such as physiology, chemistry, and physics furnish to medicine) you will have to find out how to teach for yourselves, and in finding out you can contribute to other teachers.

As an example, let us take a problem which you share with many other professions, the problem of when to teach by precept and when to teach by example and direct participation—the old controversy of the classroom versus the ward. The classroom makes possible great savings in time, is economical in its demands on facilities and personnel, and permits the communication of great amounts of content. Ward experience makes great demands on time, necessitates elaborate facilities, requires extensive staffing, and permits only the communication of limited content.

One stresses passive acceptance, the other active participation. Both can create boredom, be lacking in significance to the student, and stress inconsequentials and trivialities if not developed correctly. Under the guise of fulfilling a necessary educational function, on-the-job training or ward experience can easily become a rationalization for obtaining a cheap and controllable labor force.

This last is an ever present danger. From the medical internship, through the psychological internship, to the combined ward-and-classroom structure so typical of nursing education, the temptation is always present to distort

and discount the primary educational function of such experience in favor of getting the necessary work done. Education competes with earn as you learn, and for the student involved, earn as you learn can easily deteriorate into work as you mark time.

Economic expediency may seem to justify the mixture of service and educational functions, but a solid, factual, objective evaluation of the ultimate cost of the present system might well indicate the economic desirability of separating service and educational functions to the improvement of both. This is not to underrate the educational value of experience with patients in the treatment situation, but rather to ask that such experience be provided primarily as an educational one, with service benefits secondary and incidental. We should practice what we preach, and, incidentally, what we advertise in recruiting. If you could shed further light on this question, so important in nursing education, of the proper blend of didactic and practicum training in the learning experience, you would benefit all education, professional and otherwise.

Recruitment

The questions of what to teach and how to teach it are often viewed as abstract issues to be settled by selecting the ideal content and then arbitrarily applying the best teaching techniques that can be drawn from educational practice and theory. Nothing could be farther from the truth. What you teach and how you teach it will inevitably and inexorably be governed by the people whom you have to teach. In the final showdown, education is always governed by the capabilities of the student body concerned. Selection of students can answer some of these problems, but selection can only be practiced when the available pool of potential students is large enough to permit it. Because of this I should like to devote my concluding remarks to some aspects of recruitment since it is a basic, limiting factor that ultimately will control any educational structure you may erect.

Many of the problems of recruitment cannot, of course, be answered with any finality until there is a clear definition of what a nurse is to be. Until this is decided, the available pool of potential manpower cannot be determined with any accuracy. In turn, however, what a nurse is to be will be governed in part by who is available to become a nurse, so the two questions must be considered side by side with the ultimate outcome decided by their interaction.

There are three specific questions I should like to raise concerning recruitment. How large a pool of nurses can our economy provide? What compromises may be necessary in professional goals if the available pool is to be recruited successfully? What special problems arise from the fact that nursing is predominantly a female profession? There are no easy answers, but the questions must be raised, since they are basic to and will subtly determine the effectiveness of your consideration of the dynamics of teaching.

Manpower planning, in the sense that demand is carefully considered against the potential supply, has never been typical of the professions. The usual approach is to assume the profession is good in the sense that it fills a social need, to get assurance of social demand in the form of job opportunities and then to proceed to train on the assumption that manpower in the form of available trainees is unlimited. If it is not available at the desired ability level, then competitive recruitment and the demands of professional staffing inevitably dictate a lowering of training standards until the desired personnel output is attained. Thus, however brave and ambitious your hopes for nursing may be, however ideal the curriculum you may raise as your goal, what a nurse is and how you train her ultimately are limited by the quality of your candidates.

Even assuming the availability of the desired number of trainees of suitable quality, you are operating in a competitive market. That they are there is no guarantee that you can get them. Will nursing as you project it for the future satisfy the desires of the young woman of the future? Here I think you will feel most strongly the conflict between the bedside patient care ideal of the past and the intruding concept of the nurse as higher-level administrator.

One of your typical career patterns of the past has been the nurse serving for a few years after her training is completed and then leaving to marry, perhaps returning some years later to resume her work. What happens to this pattern under the changing concepts of nursing? It certainly is not typical of the other professions. We rarely find a doctor or lawyer practicing for four or five years, leaving to run a farm or industry for 10 years, and then returning to medicine or law. Higher-level duties demand not only higher-level training, but continuing experience and development on the job. This is one difference between a profession and an avocation. Without a supply of professional women you cannot have a profession.

The usual problems of a professional career for women are further complicated in nursing by the fact that it is a predominantly female profession. These problems exist for women in medicine, in law, in dentistry, in psychology, etc., but here women are in a minority and the cultural changes that might effect the recruitment of women effect so small a portion of the working force as to be inconsequential. There is always the main body of male manpower to stabilize over-all recruitment. But any cultural and social changes that might effect the professional desires and goals of women will be immediately and vitally felt in nursing recruitment and personnel. Safeguards against this may be necessary in your educational structure if you are to attain professional stability. You may have to inculcate career dedication as well as the principles of nursing if you are to survive.

My comments perhaps have been unduly critical, since I have confined myself to raising problems rather than reviewing accomplishment, to asking questions rather than furnishing easy answers. I have done so because the human conflict between the dream and the reality is so fundamental and because if they are not brought together and integrated the result is psychotic disintegration. Man may live with dreams, but he survives through his grasp of reality. The dream itself is nothing unless we can actualize it. Because of this, reality must always set the limits of our dreams. Without it we are left with phantasy.

There is no field in our American life in which this conflict between the dream and the reality is more pressing than in the field of education, and within education no area in which the conflict is more dangerous than in professional education, particularly for a young, aspiring profession which has not as yet completely found itself. Hard-headed thinking and constant reality-testing must be your guide. This will not discourage you. In my contacts with professional nursing, three of its qualities have never failed to impress me—its intelligence, its energy, and its tremendous tenacity of purpose. Certainly these should see you through.

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Recognizing and treating allergy in children may prevent further complications in adulthood. Some of these difficulties are discussed in the last in a series of four articles on allergy.

ALLERGY in CHILDREN:

Some Special Problems

by **SAMUEL M. FEINBERG, M.D.**
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MOST allergies begin in childhood. Herein lies the real significance of understanding allergies in children, so that you and the physician can take part in recognizing their existence, their care, and the steps necessary to prevent dire results as the child gets older. To discuss all phases of allergy in children would take much space. This article, therefore, involves a discussion of some special problems connected with such allergy. It is hoped that an acquaintance with these problems will be of help to the infant nurse, school nurse, and general duty nurse in observing and guiding the destiny of the allergic child.

The Asthma Problem

Asthma is the most serious allergic disease in children. While the actual figures are not known, conservative opinion estimates that there are more than two million asthmatic children in this country. Whereas the cause of asthma in adults is a puzzle in a large percentage of cases, in children the vast majority of cases are ascribed to allergy.

The first few months or even the first year or two of asthma in a child may fool the parents, doctor, and nurse. It may not behave like the typical adult asthma, with terrific labored breathing and wheezing; it may consist only of a recurring spasmodic cough. If such a cough persists or recurs frequently, and common causes (bronchial infection, tuberculosis, foreign body, etc.) have been eliminated, bronchial allergy should be considered. It is common for children to begin bronchial allergy in this manner. Sooner or later the typical asthma attacks develop.

Outgrowing asthma is another popular illusion. It is true that at times mysterious events take place for which no explanation is apparent, and the child loses his asthma. But in the majority of patients no such miracles are forthcoming, unaided. Something must be done, either to remove the cause or to immunize the patient to it, before we can expect a child to lose his asthma. Waiting passively for a child to outgrow asthma is like letting a boat drift through a mined sea. Disaster might be accidentally escaped but such a procedure is too risky. The child with asthma is too prone to develop chronic changes; complications include emphysema (stretched lungs with constant shortness of breath), which would disable him for life; emotional effects and social problems; and interference with schooling. Asthma could later handicap him in his gainful occupation.

In the child, even more than in the adult, it is important to recognize that he has asthma or potential asthma. It is important to get at the cause by observation, skin testing, and by a combination of these methods. It is important to do everything possible to minimize the effects of the allergy on the respiratory organs.

The Eczema Problem

Eczema is a skin disease which usually begins in infancy or early childhood. The itching rash involves mainly the face, neck, bends of the elbows, and behind the knees, but may occur also on the rest of the body. Most cases disappear during infancy, yet a good many persist during later childhood, and some persist through adult life.

It is important to recognize this as an allergic disease. Although the cause for about half of these cases cannot be found, there is reason to believe that this disease is allergic. The major evidence is as follows:

- Eczema occurs in the families of allergic people.
- A very large percentage of those who have eczema later develop other allergies, such as asthma and hay fever.
- The eosinophil cells in the blood are increased in number, as happens in other allergies.
- A large percentage of those with eczema show a positive skin test to foods or to air-borne substances.
- In a good many of these cases

the reacting substance may be traced as the true cause.

Severe eczema is important in its own right. It may weaken the child, produce infections, and it can result in mental and social problems. Even more important, we should recognize that we are dealing with an allergic youngster. It may help a great deal to discover his allergies in order to do everything possible to minimize his chances for developing other allergies, such as asthma.

Hay Fever and the Stuffy Nose

Seasonal hay fever and year-round nasal stuffiness and sneezing in children are very common ailments and their sufferers number several million. They are important from the standpoint of the suffering and inconvenience produced in these youngsters. But they are even more important because these allergies are the forerunners of more serious disease. A chronically stuffed nose frequently leads to sinus infection and to growth defects in the upper jaw, which result in malalignment of teeth. Allergy of the nose is the most common cause of orthodontic deformities resulting in overbite and requiring prolonged treatment with braces. In at least one-third of the instances of allergy of the nose, asthma, with all its potential complications, is the final result. Doing something for the nasal allergy can prevent the child from becoming asthmatic.

Special Aspects

"Too young for skin tests" is a remark often heard from parents and even doctors. A child is never too young for skin tests, providing the condition justifies it. A trace of eczema or an occasional sniffle now and then does not require skin tests, but neither would it in an adult. When skin tests are done the child will cry, of course, but he would do the same thing if he were only examined. Skin tests produce very little pain, and when done under the direction of an experienced person, are perfectly safe. The skin of the young child will react almost as well as the skin of anyone else. In stubborn allergic conditions, such as in severe eczema or in recurring or persistent asthma, it is highly advisable that tests for allergy be made.

What's the best climate for my child? is a question posed all too often. Some people have a blind faith in climate that goes far beyond reason. What can a change of climate do? Can it help *any* allergy? Yes, it can help *some* allergies. For example, the child whose main allergy comes from ragweed pollen or another one whose allergy is caused by molds could go to *particular* areas where he would be better. But note that it would be necessary to know the nature of his allergies. Otherwise, he could be sent to a region where he could get worse. The main point is that these patients do not *need* a change of climate. The majority of the types of patients mentioned above can be immunized or made comfortable some other way at home.

If the child is allergic to dust, feathers, a dog in his home, or to foods, it is foolish to expect much from climate change. The obvious fact is that each case must first be studied carefully and the question of climate considered on its own merits. A child whose major trouble is caused by infection might get better in a more favorable warm and dry climate. But remember that even though it is common to see colds produce asthma in children, the underlying cause is usually an allergy. At any rate, after all the facts are known, a climate change must be made only on a trial basis first. Too many homes, families, and livelihoods have been sacrificed unnecessarily by imprudent and hasty action.

Severe allergies frequently produce behavior problems and emotionally disturbed children. Among such effects one sees peevishness, bad temper, extreme introversion, overdependence on parents, arrogance, quarrelsomeness, and many other changes. It is also true emotional upsets of one type or another can aggravate or precipitate an already existing allergy. However, there is very little evidence at present in support of the idea that in general, asthma, eczema, and similar allergic disorders are primarily on a psychosomatic basis. "But," you may say, "can you find allergy in all these children?" No, we can't, but that is no reason for giving them the label "psychosomatic" or any other label. The search for new causes is only impeded by such pigeon-holing.

Some people have gone from one extreme to the other, from a total disbelief in allergy to a rigid acceptance that every little positive skin test is of the utmost importance. In inhalant causes the skin tests have a high degree of correlation with the cause, but foods are more fallible. Too many children are on a long-term strict diet because of positive skin tests to these foods. One *must* prove that such diets are necessary, because irrational diets may result in great nutritional harm.

There is a great deal of interest and also misconception about cortisone and cortisone-type drugs. Some people want it for every little sniffle or itch, while others would not allow the use of these drugs in their children even if the child were completely disabled. Neither attitude is rational. Most cases of allergy can be treated without cortisone drugs; simpler medicines will be adequate and faster. But there are situations where cortisone drugs are extremely useful: They can tide a child over a critical period in a severe attack of asthma. In chronic asthma they may have to be used for an extended period. They may be helpful in severe eczema, allergic blood conditions, and other serious allergies. Since it is true that these drugs can produce important side effects, the child should be observed regularly by the physician. Whatever side effects do occur are not permanent. They are reversed to normal by stopping the drug.

Prophylaxis

We have already referred to some measures indicated in the prevention of asthma, its complications, etc. Several other items should be mentioned here. Most serious allergy is inherited; if both sides of the family have allergy, the offspring is even more likely to have allergy and to develop it early. In allergic families the early feeding of the infant with certain foods is more likely to produce sensitization. This holds true particularly of such foods as egg, fish, and nuts. In an allergic child or one coming from an allergic family unnecessary exposure to agents likely to sensitize should be avoided. This includes exposure to cats, horses, perhaps dogs, weeds, etc. Respiratory infections should also be avoided since they tend to break down the tissue resistance.

Immunizations against infectious diseases are important not only to prevent such diseases, but also to remove the necessity of subsequent use of antitoxins which come from horse serum and which could produce serious reactions in allergic children Thus the use of tetanus and diphtheria toxoid is particularly important in immunizations, since they are not made from animal serum.

In connection with injections it is important to recognize the fact that penicillin should not be given for every minor infection. The child who has had several injections of penicillin when it was not essential may be handicapped when a serious infection presents itself after he has become sensitized to penicillin. It should also be remembered that all injections be given with caution and forethought. If the polio virus vaccine has some penicillin, ask yourself the question: Is the child allergic to penicillin? The influenza vaccine is grown on egg. Is the child allergic to egg?

These are among the items that are concerned in allergy in children. The final question you might ask yourself is: As a nurse, how do I fit in with these problems and how can I improve the fate of these children?

NURSING WORLD Reports

(*continued from page 7*)

people, doors, or other objects. Many falls are caused by wearing improper shoes—sling-type heels cause many women to turn their ankles; sandal-type shoes which leave all the toes exposed result in stubbing the toes while going up stairs; and high heels with leather lifts often slip on waxed floors.

Other common causes of office accidents are leaning backwards in swivel and typist chairs, placing sharp objects in waste baskets, and carrying pencils behind the ear.

Two Joint Sessions

Nurses have been invited to attend one of the two American College of Surgeons 1959 Sectional Meetings, at which the indispensable role of the nurse on the health team and her individual responsibility in keeping up to date with surgical nursing trends will be discussed.

One meeting will be held in St. Louis, Mo., between March 9 and 12. The other sectional meeting is scheduled for April 6-9 in Montreal, Quebec. Since nurses will be guests of the college, no registration fee will be charged.

W.H.O. Conference

Nurses and physicians from 26 countries attended the World Health Organization's European Conference on Public Health Nursing, held recently in Helsinki, Finland. Throughout the conference, and especially in the final session, when members from different professions discussed aspects of the conference which seemed most valuable to them, an international and inter-professional tone prevailed.

Representatives at the conference concluded that the team of physician, public health nurse, and social worker should be flexible enough to permit one of the members to take the lead, when necessary. Furthermore, although it is necessary for the nurse to interest herself in social conditions affecting health, she cannot be efficient both as a welfare and as a health worker.

It was also felt that the public health nurse should provide a generalized, rather than specialized, service, so that only a small number of professional workers become involved with the patient and his family. It will be necessary, however, for the nurse to rely on specialized consultant nurses for help with the more difficult problems, since the public health nurse must fulfill many functions.

Although opinion varied about whether basic nursing education should provide sufficient preparation for public health nursing or whether nursing in this field calls for special supplementary courses, participants did agree that the public health content of the basic program should be extended.

The members of the conference also discussed geriatrics and accident prevention and the need for using nurses economically. Another topic brought up was the necessity of providing increased opportunities for nurses who retired from nursing when they married, but who are ready to resume nursing, to some extent, once their children have grown.

In discussing the roles of voluntary and state-controlled services in communities where both exist, the conference saw that the role of each in the over-all health program must be identified and the activities of both coordinated. There should also be established a list of priorities for action in meeting public health needs.

Traineeship Extension Urged

The Evaluation Conference on the Professional Nurse Traineeship Program, which met in Washington, D. C., during August, concluded that the traineeship program has proved beneficial in partially relieving the shortage of teachers, administrators, and supervisors in nursing. The conference recommended that the program be continued for another five years in essentially the same way it has been operating since it was started.

The graduate nurse traineeships were authorized under the Health Amendments Act of 1956, which called for "the appropriation of such sums as Congress may determine" each year for a three-year period. The law also provided for the conference to be held in 1958 to "assist in appraising the effectiveness of the legislation and the need for possible modifications."

Sixty-eight representatives from nursing education, nursing services, public health administration, hospital administration, medicine, general education, and national professional organizations attended the conference.

The conference report will be submitted to Congress by the Surgeon General before Jan. 1, 1959.

A.N.A. Appointments

Two nurses were recently appointed to positions on the Professional Counseling and Placement Service of the American Nurses' Association. Mrs. Evelyn B. Ferguson is the new associate executive secretary of the P.C. & P.S., replacing Mary Mitchell, who was unable to move from Chicago to New York with the service. New assistant executive secretary is Helen F. Marsh.

Mrs. Ferguson had served for eight years as assistant executive secretary with the P.C. & P.S. Before assuming her new position, Miss Marsh had been assistant to the dean of the Rutgers University College of Nursing.

Silver Anniversary

Katherine M. Disosway, education director of the Visiting Nurse Association of Brooklyn, recently celebrated her 25th Anniversary with the agency.

In her present position, Miss Disosway is in charge of the educational program for V.N.A. staff nurses and is responsible for student nurses who come to the V.N.A. for field work in public health nursing.

Miss Disosway is treasurer and member of the board of directors of the Nurses Association of the Counties of Long Island (District 14 of the N.Y. State Nurses Association), a member of the Southern N.Y. League for Nursing, a member of the Brooklyn College Advisory Committee for Nursing Science Program, and is active in several other nursing activities. She is a graduate of The Presbyterian Hospital School of Nursing and holds a B.S. in Nursing from Women's College, University of North Carolina, and an M.A. from Teachers College, Columbia University.

Miss Bunge Appointed Director

Helen Lathrop Bunge has been named director of the University of Wisconsin School of Nursing. She will also serve as an associate dean of the Medical School and professor of nursing.

Miss Bunge will join the faculty of the school on Feb. 1, 1959, after completing her duties as executive officer of the Institute of Research and Service in Nursing Education at Teachers College, Columbia University. When she joins the University of Michigan School of Nursing faculty, she will lead a study of the school's program.

Miss Bunge received her bachelor's degree from Wisconsin in 1928 and her graduate nurse certificate in 1930. She also received M.S. and Ed.D. degrees from Columbia University.

Nurse Receives N.B.C. Award

Carolyn Fisher, operating room supervisor at the Wills Eye Hospital, Philadelphia, Pa., was recently presented with the N.B.C. Public Service Award for her efforts in promoting the prevention, teaching, and care of blindness among eye patients. Each day she is in charge of preparations for approximately 30 operations.

Miss Fisher is a graduate of Reading General Hospital.

CLASSIFIED ADVERTISEMENTS

DIVISIONAL ADMINISTRATOR: Out-patient, admitting, and X-ray nursing services, including service and education. Salary upon request. Apply Director, Cook County School of Nursing, Department W, 1900 West Polk St., Chicago 12, Illinois.

INSTRUCTOR, FUNDAMENTALS OF NURSING (nursing arts): Salary range $420-$455 per month, 37½-hour week. Single room, nurses' residence, $20 and $25 per month. Apply Director, Cook County School of Nursing, Dept. W, 1900 West Polk St., Chicago 12, Ill.

WORK OVERSEAS: Nurses and technicians are needed by American companies with overseas projects. Booklet tells how and where. Price $1. Satisfaction guaranteed. Free booklet on retirement in economical Mexico with each order. Publisher Rathe, Box 2013, Pasadena, Calif.

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DIRECTOR OF NURSING: Direct and co-ordinate work of nursing service and school of nursing. JCAH accredited, nonsectarian hospital of 576 beds (including 126 nonacute beds) and NLN-accredited diploma program school of 160 students. Prefer masters degree in education or administration with successful experience. Excellent salary, personnel policies. City of 110,000 located on beautiful Lake Superior. Write Personnel Director, St. Luke's Hospital, Duluth 11, Minn.

PSYCHIATRIC NURSING: Assistant Director of Education in a fully accredited private hospital near Baltimore, Md. Give academic and experience background when applying to Theresa G. Muller, Director of Nurses, The Sheppard & Enoch Pratt Hospital, Towson 4, Md.

NURSING SUPERVISOR-ADMINISTRATIVE: 400-bed private general hospital with 150-student school of nursing. Expansion program to be completed fall 1958. Applicant should have a B.S. degree with advanced preparation in supervision and teaching, and at least three years of nursing experience, including one year as a head nurse. Liberal salary range and employee benefits. Excellent working conditions in one of midwest's foremost institutions, centrally located in city and convenient to outstanding residential and shopping facilities. Contact Personnel Department, Milwaukee Hospital, 2200 W. Kilbourn Ave., Milwaukee 3, Wis.

BARNES HOSPITAL: Offers to graduates of accredited schools of nursing a comprehensive course in anesthesia, embracing administration of nitrous oxide, ethylene, cyclopropane, ether, barbiturates, etc. Modern techniques taught include face-mask, endotracheal, intravenous, rectal, etc. Write to Mrs. Dean Eberhardt Hayden, Director, School of Anesthesia, Barnes Hospital, St. Louis 10, Mo.

PSYCHIATRIC NURSING: Clinical Instructor in a fully accredited private hospital near Baltimore, Md. Give academic and experience background when applying to Theresa G. Muller, Director of Nurses, The Sheppard & Enoch Pratt Hospital, Towson 4, Md.

INSTRUCTOR — CLINICAL, EVENINGS & NIGHTS: Should have B.S. degree in nursing education and minimum of two years' experience in two of the following positions: instructor, assistant instructor, head nurse. 400-bed private general hospital with expansion program to be completed in fall 1958. 150-student school of nursing, three-year diploma course. Contact Personnel Department, Milwaukee Hospital, 2200 West Kilbourn Ave., Milwaukee 3, Wis.

PSYCHIATRIC NURSING: Instructor (Male) for attendant program in a fully accredited private hospital near Baltimore, Md. Give academic and experience background when applying to Theresa G. Muller, Director of Nurses, The Sheppard & Enoch Pratt Hospital, Towson 4, Md.

PSYCHIATRIC NURSING ADMINISTRATIVE ASSISTANT: For 100-bed teaching institute. Psychiatric supervisory experience required. Advanced preparation in administration preferred. Salary dependent on qualification. Paid vacation, sick leave, social security, 40-hour week. Apply Nursing Director, Nebraska Psychiatric Institute, University of Nebraska Medical Center, 602 South 44 Ave., Omaha 5, Neb.

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Staphylococcal Infections . . .

(*continued from page 9*)

cilities of her own local and state health departments. They, in turn, may utilize the services of teams of the United States Public Health Service's Communicable Disease Control Center in Atlanta, Ga.

Physicians and nurses take pride in the quality of their hospital services. Thus, it is not very comfortable to recognize that something has arisen which may detract from the excellence of their services. This means there is need for studying the situation and making possible changes. Making changes requires time, energy, and readjustment. Naturally, we all have some reluctance to change. But failure to do so may jeopardize the health and well being of hospital patients entrusted to our care.

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